Management of constipation in preventing urinary tract infections in children: a concise review

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ABSTRACT

Objectives: Constipation is a common problem in children. Chronic functional constipation (CFC) has been claimed as a condition that may increase the risk for urinary tract infections (UTIs). Dysfunctional voiding (DV) and lower urinary tract dysfunctions (LUTD) with chronic constipation are referred to dysfunctional elimination syndromes (DES). The aim of the present review is to look at the management of constipation in children with CFC or DES in reducing the risk of recurrent UTIs.

Methods: We performed a literature search on electronic databases (Pubmed and Scopus) for relevant clinical trials investigating the results of one or more treatments for children's constipation in the term of UTIs recurrence.

Results: The search strategy identified 20 valuable clinical trials. The studies are not homogenous but showed an improvement in UTIs occurrences in children managed for bowel dysfunction.

Conclusion: In conclusion, children referred to a pediatric nephrologist for UTIs should include an inquiry bowel habits and those with a positive assessment for bowel dysfunction needs the collaboration with a pediatric gastroenterologist with a multidisciplinary approach.

Keywords: Children, constipation, dysfunctional elimination syndromes, dysfunctional voiding, urinary tract infection

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defecation frequency of less than three times, a fecal incontinence, frequency more than once, passage of large stools that clog the toilet, a palpable abdominal or rectal fecal mass, stool withholding and painful defecation [9]. CFC is chronic constipation without evidence of pathological conditions [10] and, at present, the most accepted definitions for CFC are the Rome III criteria [11]. In particular, sensation of anorectal blockage, straining during defecation and infrequent bowel movements are of great accuracy for the diagnosis of CFC [12]. Constipation may play a role in function and dysfunction of the urinary tract [13].

Dysfunctional voiding (DV), that refers to an intermittent and/or fluctuating uroflow rate due to involuntary intermittent contractions of the striated muscle of the external urethral sphincter or pelvic floor during voiding in normal individuals [14], and lower urinary tract dysfunctions (LUTD), that refers to patients with problems of bladder function [14], as dysfunctional elimination syndromes (DES) [15] with CFC [16]. DES and CFC increased the risk of UTIs in children [15, 17]. In agreement, it has observed recurrent UTIs in 25% of boys and 66% of girls among 180 patients with CFC [19], and in 62% of girls among 80 patients with DES [18].

Children with UTIs have more symptoms of constipation than without [20]. Wan et al. [21] suggested that up to 90% of children with UTI could have dysfunctional voiding or constipation habits. Although the degree of fecal loading, as seen on a plain abdominal radiograph, is not synonymous of constipation, there is a significant association between the degree of fecal loading and UTIs [22]. Decreased bladder filling, impression of the bladder wall provoking overactivity, and pelvic floor discoordination caused by withdrawal manoeuvres as a response to painful defecation can have an important clinical meaning [23]. Another hypothesis is that constipation can figure bacterial stasis with huge proliferation and translocation of the same bacteria into genitourinary apparatus. In fact, it has reported a correlation between intestinal bacterial stasis, methanogenic intestinal flora and UTIs [24].

The general approach to the child with functional constipation comprises dietary interventions (high fibre diet, hydration changes), behavioural change, regular toilet habits and laxatives to assure that bowel movements occur at normal intervals with good evacuation [11].

The aim of the present look at to check if management of constipation in children with CFC or DES reduce the risk of UTIs recurrence.

METHODS

We performed a systematic literature search on electronic databases (Pubmed and Scopus) for relevant clinical trials published from January 1985 to June 2018, investigating the results of one or more treatments for children’s constipation in the term of the resolution or amelioration of UTIs recurrence. To find relevant articles in these electronic databases, we used the keywords constipation OR dysfunctional elimination syndrome OR dysfunctional voiding AND urinary tract infection AND children.

Studies were qualified for inclusion if they were clinical trials (excluding observational studies, letters, case reports, conference abstracts, studies on animals and comments), searching for the role of one or more treatments for constipation in the term of the resolution or amelioration of UTIs recurrence.

First, we screened the list of titles and abstracts (total number identifies: 321); then we selected clinical trials and the articles of interest in their entirety. The strategy identified 20 clinical trials. We extracted the first author and year of publication, the number of cases, characteristics of constipation and treatment, and time of follow-up. We extracted information on the prevalence of constipation and UTI before and after the treatment.

RESULTS

Clinical trials

Twenty clinical trials (Table 1) involving patients with CFC or DES reported different treatment regimens for constipation (laxatives, enemas, high-fibre diet, biofeedback therapy, pelvic floor muscle exercises, sacral neuromodulation, regular voiding, pharmacotherapy etc.) [23, 25-43].

Studies that showed a significant reduction of UTIs related to DV [26-28, 40] or DES [29, 30, 32] or LUTD [42]. Other studies did not report if the results
Table 1. Characteristics and analysis of the included clinical trials

<table>
<thead>
<tr>
<th>Clinical trials</th>
<th>n. (M/F)</th>
<th>Mean age (range)</th>
<th>Main pathology</th>
<th>Treatment</th>
<th>Follow-up</th>
<th>n. of patients with constipation before/after</th>
<th>n. of patients with UTI before/after</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chrzan 2008 [23]</td>
<td>50 (6/44)</td>
<td>9.6 (6.5-12 yrs)</td>
<td>CFC, recurrent UTIs</td>
<td>Colonic washout enemas</td>
<td>6 mos</td>
<td>50/33 p = n.a.</td>
<td>50/20 p = n.a.</td>
</tr>
<tr>
<td>Vesna 2010 [26]</td>
<td>86 (35/51)</td>
<td>7.1 ±2.5 (3-13 yrs)</td>
<td>DV</td>
<td>Group A) Standard urotherapy, pelvic floor exercises</td>
<td>1 yr</td>
<td>Group A 15/0 p &lt; 0.0001</td>
<td>Group A 15/9 p &lt; 0.05</td>
</tr>
<tr>
<td></td>
<td>Group A 43 (15/28)</td>
<td>Group B 32 (9/23)</td>
<td>Group B) conservative treatment</td>
<td>Laxatives; antibiotic prophylaxis if UTIs recurring in both groups</td>
<td></td>
<td>Group B 10/4 p &lt; 0.05</td>
<td>Group B 15/9 p &lt; 0.05</td>
</tr>
<tr>
<td>Vesna 2011 [27]</td>
<td>86 (35/51)</td>
<td>7.5±2.5 yrs</td>
<td>DV</td>
<td>Group A) diaphragmatic breathing, pelvic floor muscles retraining plus</td>
<td>1 yr</td>
<td>Group A 15/0 p &lt; 0.0001</td>
<td>Group A 19/6 p &lt; 0.001</td>
</tr>
<tr>
<td></td>
<td>Group A 43 (15/28)</td>
<td>Group B 32 (9/23)</td>
<td>Group B) regular voiding, hydration, posture, laxatives; antibiotic</td>
<td>Pharmacotherapy (11 anticholinergics, 11 desmopressin, 15 antibiotic prophylaxis); constipation treatment (education and laxatives); diaphragmatic breathing exercises; pelvic floor muscle exercises</td>
<td></td>
<td>Group B 10/4 p &lt; 0.05</td>
<td>Group B 15/9 p &lt; 0.05</td>
</tr>
<tr>
<td>Zivkovic 2012 [28]</td>
<td>43 (15/28)</td>
<td>7.5±2.5 (5-13 yrs)</td>
<td>DV</td>
<td>1 yr</td>
<td></td>
<td>15/0 p &lt; 0.0001</td>
<td>19/6 p &lt; 0.0001</td>
</tr>
<tr>
<td>Kajbafzadeh 2011 [29]</td>
<td>80 (18/62)</td>
<td>8.5±2.7 yrs</td>
<td>DES</td>
<td>Group A) animated biofeedback therapy and behavioral modification</td>
<td>6 and 12 mos</td>
<td>Group A 25/8/8 p = 0.01</td>
<td>Group A 14/2/4 p = 0.02</td>
</tr>
<tr>
<td></td>
<td>Group A 40 (8/32)</td>
<td>Group B 40 (10/30)</td>
<td>Group B) conservative therapy (only behavioral modification)</td>
<td>Group B 20/12/12 6 mos: p = 0.01</td>
<td></td>
<td>Group B 12 mos: p = 0.009</td>
<td>Group B 22/5/10 6 mos: p = 0.3</td>
</tr>
<tr>
<td>Humphreys 2006 [30]</td>
<td>23 (8/15)</td>
<td>(6-15 yrs)</td>
<td>Severe DES</td>
<td>Sacral neuromodulation, medical therapy</td>
<td>(4.37 mos mean 13.3 mos)</td>
<td>15/3 p = 0.001</td>
<td>18/6 p = 0.0001</td>
</tr>
<tr>
<td>De Paepe 2000 [31]</td>
<td>20 (2/18)</td>
<td>M 4.5 yrs F 4.44 yrs</td>
<td>DV</td>
<td>Training program, biofeedback, antibiotic prophylaxis if UTIs</td>
<td>6-12 mos</td>
<td>8/3 p = n.a.</td>
<td>8/0 p = n.a.</td>
</tr>
</tbody>
</table>
### Table 1 continued. Characteristics and analysis of the included clinical trials

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<th>n. of patients with UTI before/after</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vasconcelos 2006 [32]</td>
<td>56 (18/62)</td>
<td>Group 1 10.8 ± 1.9 yrs Group 2 10.3 ± 2.6 yrs</td>
<td></td>
<td>DES</td>
<td>12 mos</td>
<td>Group 1 11/7 p = n.s Group 2 11/9 p = n.s</td>
<td>Group 1 8/1 p = 0.023 Group 2 13/3 p = 0.004</td>
</tr>
<tr>
<td>Yagci 2005 [33]</td>
<td>168 (16/152)</td>
<td>7.44 ± 2.24 yrs (5-14) yrs</td>
<td></td>
<td>DV</td>
<td>6 mos and 2 yrs</td>
<td>26/7/9 p = 0.5</td>
<td>102/17/13 p = 0.125</td>
</tr>
<tr>
<td>McKenna 1999 [34]</td>
<td>41 (8/33)</td>
<td>7.2 yrs (5-11) yrs</td>
<td></td>
<td>DV</td>
<td>(3-15 mos) mean 7 mos</td>
<td>6 Improved: 66% Cured: 34% p = n.a.</td>
<td>22/3 p = n.a.</td>
</tr>
<tr>
<td>Barroso 2006 [35]</td>
<td>36 (n.a.)</td>
<td>7 yrs (3-14) yrs</td>
<td></td>
<td>LUTD</td>
<td>(4-24 mos) mean 13.8 mos</td>
<td>12/3 p = n.a.</td>
<td>25/4 p = n.a.</td>
</tr>
<tr>
<td>Petronijevic 2007 [26]</td>
<td>9 (girls)</td>
<td>6.1 yrs (3-11) yrs</td>
<td></td>
<td>DV</td>
<td>6 mos</td>
<td>2/1 p = n.a.</td>
<td>8/2 p = n.a.</td>
</tr>
<tr>
<td>O’Regan 1985 [37]</td>
<td>47 (girls)</td>
<td>8.2 ± 2.53 yrs</td>
<td>Recurrent UTIs, constipation</td>
<td>Enema regimen</td>
<td>12±2 mos</td>
<td>47/2 Encopresis 21/1 p = n.a.</td>
<td>47/3 p = n.a.</td>
</tr>
<tr>
<td>Loening-Baucke 1997 [38]</td>
<td>234 (176/58)</td>
<td>9 ± 3 yrs (5-18) yrs</td>
<td>CFC, encopresis</td>
<td>Disimpaction (hypertonic phosphate enemas OR hyperosmolar milk-of-molasses enemas), fiber-rich foods, laxatives, education, prophylaxis if UTIs recurred</td>
<td>12 months (mean, 15 months )</td>
<td>234/112 p = n.a.</td>
<td>25/0 p = n.a.</td>
</tr>
<tr>
<td>Loening-Baucke 1989 [39]</td>
<td>97 (69/28)</td>
<td>9.0 yrs (5-14.5) yrs</td>
<td>CFC, overflow incontinence</td>
<td>Laxatives, high fiber diet, bowel training</td>
<td>12 mos</td>
<td>97/43 (F&gt;M)</td>
<td>n.a. (UTI in recovered 3/43, UTI in non-recovered 11/54; p = n.s.</td>
</tr>
<tr>
<td>Khen-Dunlop 2006 [41]</td>
<td>60 (12/48)</td>
<td>8 yrs (5-14) yrs</td>
<td>DV</td>
<td>Pelvic floor training, regular voiding</td>
<td>21 mos</td>
<td>25/n.a.</td>
<td>37/6</td>
</tr>
<tr>
<td>Amira 2013 [42]</td>
<td>72 (girls)</td>
<td>8 yrs (7-10) yrs</td>
<td>LUTD</td>
<td>Standard and computer game assisted pelvic floor muscle retraining</td>
<td>(6-17 weeks) mean 11 weeks</td>
<td>36/n.a. p &lt; 0.002</td>
<td>70/n.a. p &lt; 0.001</td>
</tr>
<tr>
<td>Tugtepe 2015 [40]</td>
<td>45 (38 female)</td>
<td>8.5 ± 2.2 years</td>
<td>DV, refractory overactive bladder</td>
<td>Biofeedback therapy</td>
<td>3 months</td>
<td>8/1 p &lt; 0.05</td>
<td>20/4 p &lt; 0.001</td>
</tr>
</tbody>
</table>
were different [23, 25, 31, 34-38, 43].

Few studies applied a randomization [26, 27, 29, 32]. In two studies by Vesna et al. [26, 27] divided the patients into two groups to compare different treatment regimens for DV; both groups had significant positive results in terms of amelioration of UTI recurrence and constipation. In another study, Kajbafzadeh et al. [29] randomized patients into 2 groups (biofeedback and conservative treatment) reporting a significant improvement of both constipation and UTI recurrence. Vasconcelos et al. [32], who compared two different treatments for DES, reported in both groups a significant improvement only in UTIs recurrences, because the prevalence of constipation had not decreased at follow-up compared to baseline.

Published studies involved a variable number of patients, from small cohorts of patients to a wide number (mean 71.4 patients, range 9-234), and often were only partial [41, 42].

A study of Loening-Baucke [38] is the one with the largest number of patients. The author observed that in 234 children with known CFC and encopresis which treatment of constipation could prevent UTIs in 10% of patients with recurrent UTIs. In a study by the same author [39], treatment of constipation resulted in amelioration of the CFC but reported no results in terms of UTI incidence. Khen-Dunlop et al. [41] reported the outcome only to resolve UTI recurrences and not for constipation. A recent study involving 209 children, CFC treatment did not show a significant (not stated) amelioration of UTIs recurrences [43]. In particular, this case-control study (105 CFC children versus 104 controls) showed that the prevalence of UTI in case and control groups was 13.3% and 6.7% ($p = 0.17$), showing a large link between constipation and UTIs, but the prevalence of UTIs in case group decreased only to 3.8% after treatment of constipation [43].

A bias in the clinical trials [26-28, 31, 35, 38] was the association between antibiotic prophylaxis, used if UTIs recurred, and constipation treatment.

**DISCUSSION**

UTIs recurrence prevention in children is again a challenge question whether antimicrobial prophylaxis is still a matter of debate. It has conducted investigations to find optimal approaches to the assessment and management of UTIs and later interventions [44, 45].

Studies suggested a link between constipation and UTI recurrences in children. Guidelines for children with UTIs considered for investigate and managing of the bowel dysfunctions. The studies conducted so far reported a large reduction in UTIs occurrences in children managed for DES, DV or CFC [26, 28-30, 32, 33, 40].

American Academy of Pediatrics (AAP) published guidelines for the diagnosis and management of UTIs in febrile infants and young children younger than 2 years. No mention concerns evaluation and treatment of the associated constipation [46]. In the same way, the Italian Society of Pediatric Nephrology reports the recommendations for diagnosis and treatment of UTIs.
in children younger than 3 years, but did not mention evaluation and treatment of constipation in affected ones [47]. The American Urological Association (AUA) guidelines recommended a continuous antimicrobial prophylaxis as management of a child >1-year-old with VUR, recurrent febrile UTIs, bladder and bowel dysfunction, or renal cortical anomalies. No mention regards the constipation in affected children [48]. The European Urological Association reported that if symptoms are suggestive of LUTD (urgency, incontinence, constipation, or holding manoeuvres), should do an extensive history and examination. No mention regarded constipation management in these children [49].

Only NICE clinical guideline (https://www.nice.org.uk/guidance/qs36) reported that constipation and DV are risk factors for UTIs and should as part of history and examination on confirmed UTI. A systematic review of 27 studies (1 RCT and 26 case studies) on the role of biofeedback in DES in paediatric patients showed a rate of improvement from 18% to 100% for constipation and of 83% in cases of UTI [50]. In children with severe constipation, a structured bowel management program decreases unplanned visits to the emergency department, hospital admissions, and costs for constipation-related health care for constipation-related morbidities (abdominal pain 39%, fecal impaction 17%, urinary retention 2.2%, urinary tract infections 14%) [51].

**Limitations**

Further studies are necessary to show the effectiveness of constipation treatment regimens in preventing recurrent UTIs in children. In fact, most clinical trials, investigating the results of one or more treatments for constipation in the term of the resolution or amelioration of UTI recurrence, lacking in randomization and controlled groups. The published study results often involved small cohorts of patients or were only partial.

**CONCLUSION**

In conclusion, constipation seems to be a predisposing factor for UTIs recurrence in children. Studies were not homogenous but showed an improvement in UTIs occurrences in children managed for CFC or DES. Children referred to a paediatric nephrologist for UTIs should include an inquiry on bowel habits and those with a positive assessment for bowel dysfunction should be referred to a paediatric gastroenterologist as a multidisciplinary approach.

**Abbreviations**

CFC = chronic functional constipation  
DES = dysfunctional elimination syndromes  
DV = dysfunctional voiding  
LUTD = lower urinary tract dysfunctions  
UTI = urinary tract infection  
VUR = vesicoureteral reflux

**Conflict of interest**

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