Ashford and St. Peter's Hospitals NHS
NHS Trust

WOMEN'S HEALTH AND PAEDIATRICS
PAEDIATRIC DEPT

# Abdominal Pain Chronic Guideline

| Amendments | | | |
|---|---|---|---|
| Date | Page(s) | Comments | Approved by |
| June 2013 | New Guideline | | |
| March 2018 | | Whole document review | Paediatric Guideline Group |

**Compiled by:** Dr Bozhena Zoritch, Consultant Paediatrician

**In Consultation with**:

**Ratified by:** Paediatric Guidelines Group

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**Target Audience:** Doctors, nurses and support staff working in Paediatrics

**Impact Assessment Carried Out By:**

**Comment on this document to:** Dr Bhatti and Dr Baksh Consultant Paediatrician

# Abdominal Pain Related – Functional Gastrointestinal Disorders Paediatric Guideline, SPH

## Previous Classification Systems for Abdominal Pain in Children:

**Recurrent abdominal pain,** *Apley and Naish, 1958*
Abdominal pain that waxes and wanes, occurs for at least 3 episodes within 3 months, and is severe enough to affect a child's activities

**Chronic abdominal pain,** *Subcommittee on chronic abdominal pain, 2005*
Longstanding intermittent or constant abdominal pain. Functional in most children (that is, without objective evidence of an underlying organic disorder).

## Current Classification Systems for Abdominal Pain in Children:
## Rome IV criteria, 2016

**Functional dyspepsia** *
Must include **all** of the following (for at least once a week over at least 2 months before diagnosis):

- Persistent or recurrent pain or discomfort centred in the upper abdomen (above the umbilicus).
- Not relieved by defecation or associated with the onset of a change in stool frequency or stool form.

**Irritable bowel syndrome** *
Must include **all** of the following (for at least once a week over at least 2 months before diagnosis):
Recurrent abdominal pain, on average, at least 1 day/week in the last 3 months, associated with two or more of the following criteria:

- Related to defecation
- Associated with a change in frequency of stool
- Associated with a change in form (appearance) of stool.

Criteria fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis.

**Functional abdominal pain** *
Must include **all** of the following for at least once a week over at least 2 months before diagnosis:

- Episodic or continuous abdominal pain.
- Insufficient criteria for other functional gastrointestinal disorders.

**Functional abdominal pain syndrome** *
Must include functional abdominal pain at least 25% of the time and ≥1 of the following:

- Some loss of daily functioning
- Additional somatic symptoms such as headache, limb pain, or difficulty in sleeping

**Abdominal migraine** *
Must include **all** of the following for ≥2 times in the preceding 12 months:

- Paroxysmal episodes of intense, acute peri- umbilical pain that lasts for ≥1hours
- Intervening periods of usual health lasting weeks to months
- The pain interferes with normal activities
- The pain is associated with two or more of the following:
  - Anorexia
  - Nausea
  - Vomiting
  - Headache
  - Photophobia
  - Pallor

**No evidence of an inflammatory, anatomical, metabolic, or neoplastic process that explains symptoms.*

Initial clinical assessment:

1. Full history – exclude red flags
2. Height and weight

Red flags:

1. Persistent symptoms in the right upper and lower quadrants
2. Waking up at night because of pain
3. Dysphagia, heartburn
4. Unintended loss of > 10% body weight
5. Impaired growth
6. Delayed puberty
7. Recurrent vomiting (bilious, cyclical, protracted or worrisome to the physician)
8. Chronic diarrhoea, particularly at night
9. Evidence of GI blood loss (visible or positive FOB)
10. Unexplained fever
11. Family history of chronic IBD, celiac disease, peptic ulcer disease or other abdominal conditions
12. Abnormal physical findings eg. Palpable mass, hepatomegaly, splenomegaly, guarding
13. Arthritis
14. Disturbances of micturition
15. Disturbances of the female reproductive system (dysmenorrhoea, amenorrhoea)

Investigations:

- FBC, LFTs, CRP, ESR
- Coeliac serology
- Urine dipstick
- Stool Sample for Faecal Occult Blood

If these basic tests are **normal** no need for further investigations.
* No need for H.pylori investigation unless peptic ulcer disease suspected

Management options:

1. **Reassurance:** explain that there is no organic cause, but acknowledge that the pain is a real problem
2. **Education:** discuss pathophysiological mechanisms of chronic abdominal pain. The explanatory model of *visceral hypersensitivity* with a low individual pain threshold

helps understanding as to why they (unlike other people) have pain when the bowel wall is physiologically stretched.

3. **Psychological support:** *acceptance by parents of the role of psychological factors in the maintenance of symptoms is strongly associated with recovery*
4. **CBT:**

| CBT Element | Examples | Goal |
|---|---|---|
| Psycho-education | Education about causes<br>Teaching coping strategies | Promoting patient co-operation and supporting self responsibility |
| Relaxation | Progressive muscle relaxation<br>Autogenic training | Reduction of pain due to tension and creation of a relaxed state |
| Cognitive techniques | Distraction techniques<br>Cognitive restructuring | Learn to deal with the pain with a positive attitude |
| Behaviour-orientated techniques | Make activity plans | Restoration of functional ability in everyday life |

- The aim is not to relieve symptoms but acquire strategies for coping with the pain and continuing with normal activities.
- The pain is a trigger for coping strategies and not as an uncontrollable event.
- Reduction of avoidance behaviour (school absence, avoiding activity)

5. **Peppermint oil** in IBS (for 2/52)
6. **Pizotifen** in abdominal migraine

Management options **unlikely** to be beneficial:

1. Famotidine (H2 receptor agonist)
2. Dietary changes – added dietary fibre, lactose-free diet
3. Alternative/complimentary medicine

Management options of **unknown** efficacy:

1. Probiotics
2. Hypnosis

**References:**

1. Chronic abdominal pain in childhood. Berger MY, Gieteling MJ, Beninga MA. BMJ 2007; 334: 997-1002.
2. Recurrent abdominal pain in childhood. Bufler Ph, Gross M, Uhlig HH. Deutsches Arzteblattn International 2011; 108 (17): 295-304.