



Challenges in

Recurrent **A**bdominal

Pain in children

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Functional Abdominal Pain



Functional abdominal pain is a common disorder with a prevalence of 3–16% depending on country, age and sex.





Importance

FUNCTIONAL ABDOMINAL PAIN CAMPAIGN

As a society, ESPGHAN calls for action by inviting healthcare professionals, primary caregivers and the public to:

- Spread awareness and follow conversations on social media using the hashtag #FunctionalAP
- Educate families, friends and communities about the signs and symptoms of functional abdominal pain

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The diagnostic Rome IV criteria for functional abdominal pain must be fulfilled for at least 2 months before diagnosis, must be met at least 4 times per month, and include all of the following:

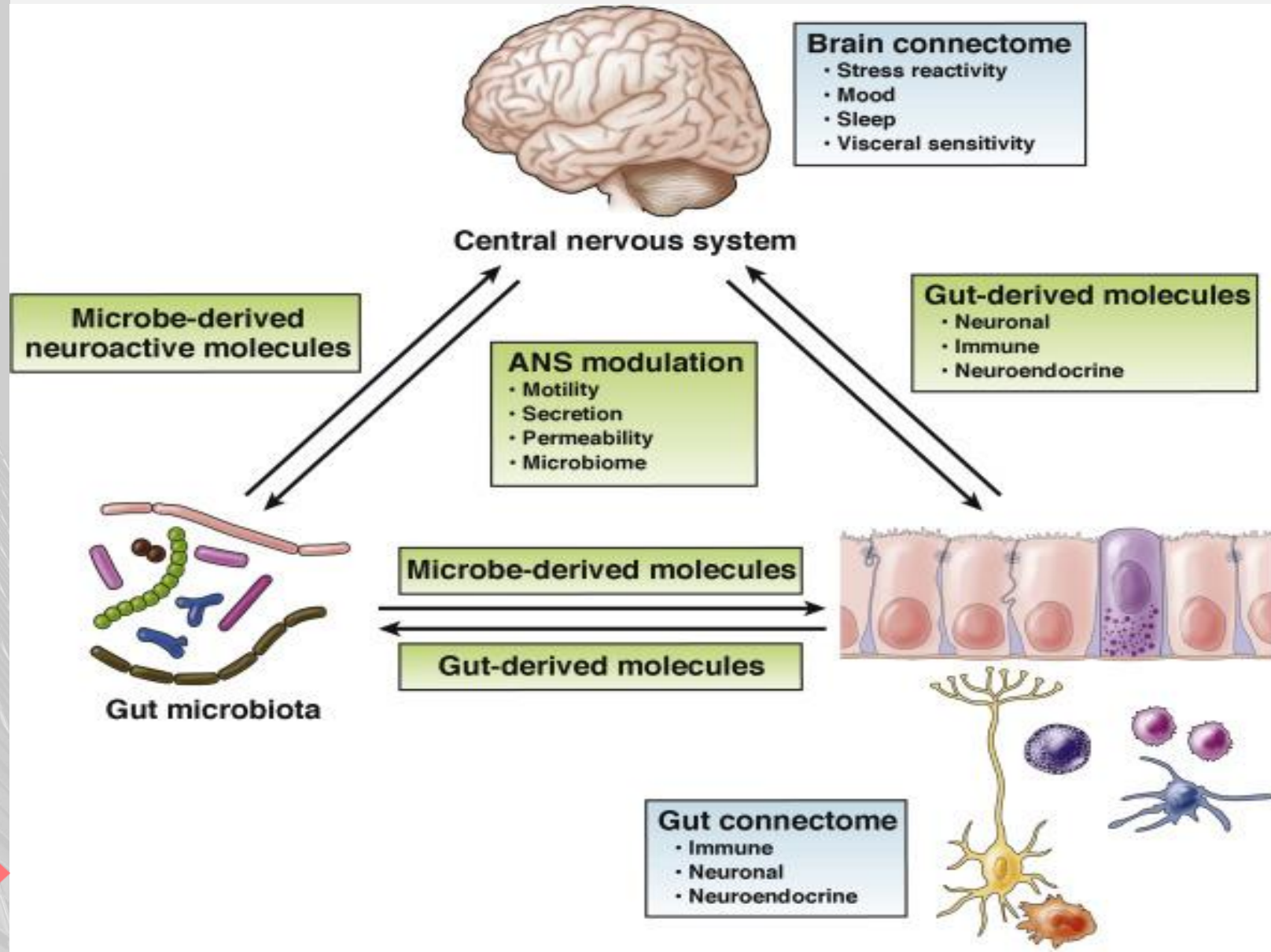
1. Episodic or continuous abdominal pain that does not occur solely during physiological events such as eating and menses.
2. Insufficient criteria for other functional GI disorders including irritable bowel syndrome, functional dyspepsia, or abdominal migraine.
3. ***After appropriate evaluation, the abdominal pain cannot be fully explained by another medical condition.***

Facts

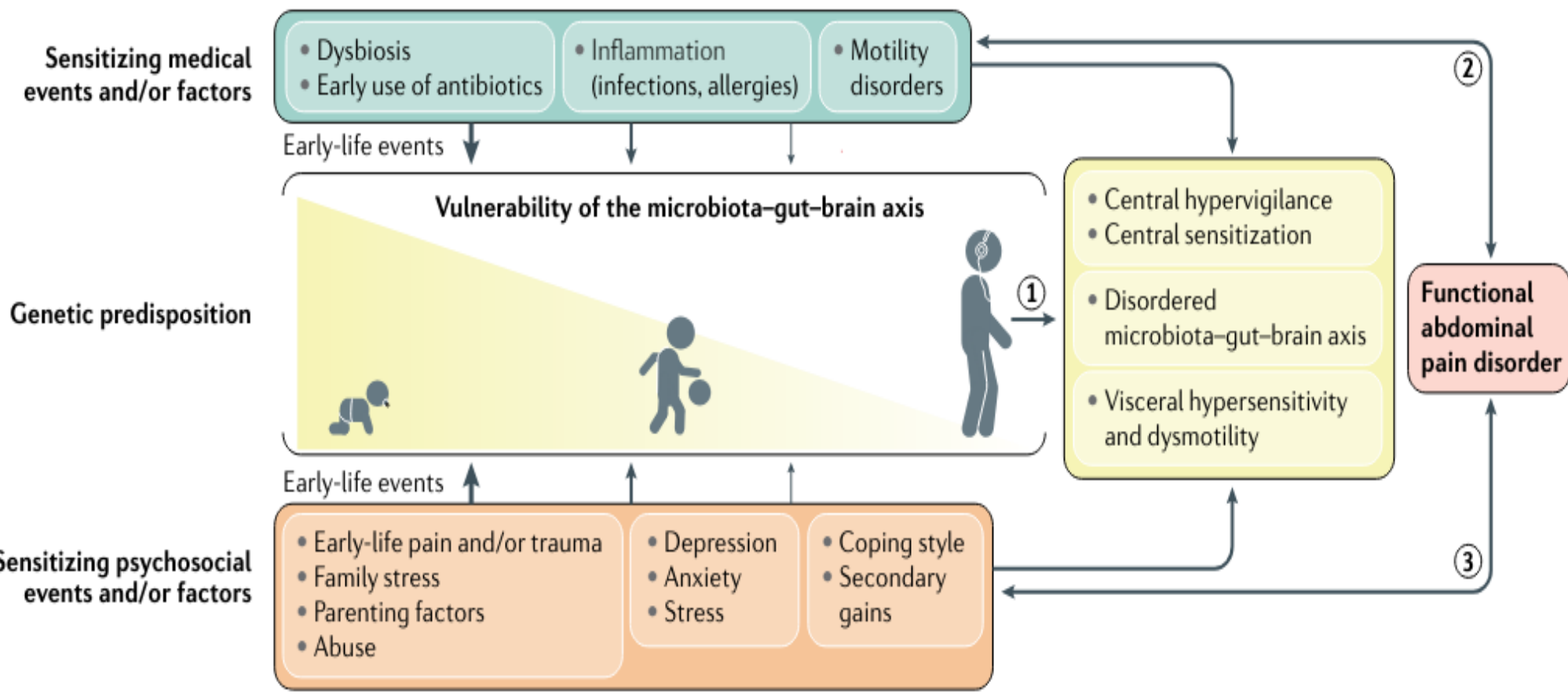


- ❖ As a change from the prior Rome III criteria, functional abdominal pain can be diagnosed based on symptoms “after appropriate medical evaluation the symptoms cannot be attributed to another medical condition” rather than the previous criteria’s requirement that there “is no evidence for organic disease.”
- ❖ This modification has allowed greater autonomy to the clinicians to use their expertise to decide whether selective testing, or, in some cases, even no testing, is needed to establish the diagnosis.
- ❖ A greater understanding of etiopathogenesis is emerging and includes *intestinal components* (inflammation, motility and the microbiota), *central factors* (psychological aspects, sensitization and/or differences in connectivity or activity of certain brain regions) as well as *extrinsic factors* (infections).

Microbiota-Brain-Gut Axis




The Importance of Exposure Time

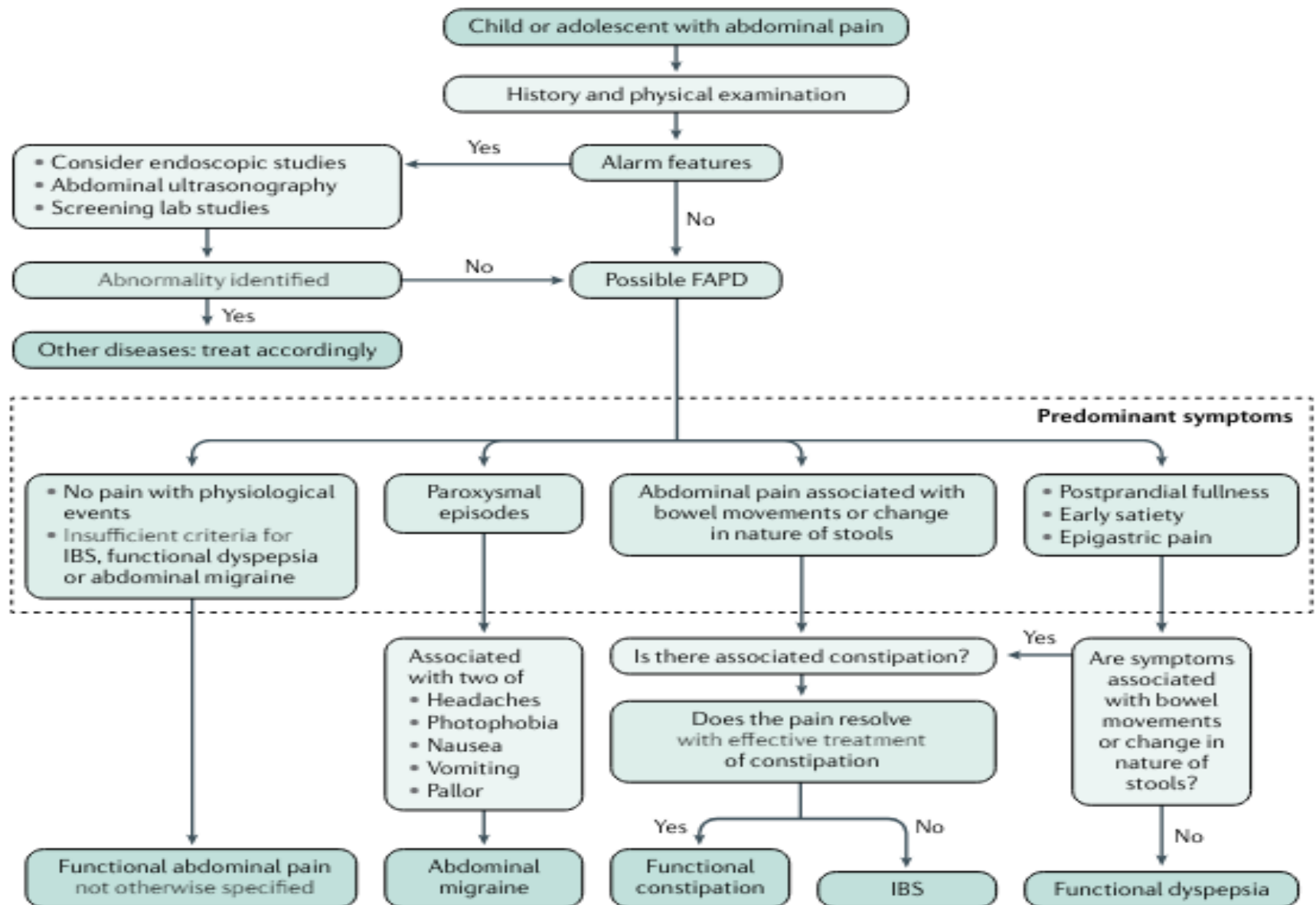


Facts



- ❖ Diagnosis is challenging but is primarily based on **avoiding unnecessary invasive diagnostic procedures.**
 - ❖ The available pharmacological interventions are limited in children and, therefore, management has focused on combined approaches, including mind-targeted interventions (hypnotherapy and cognitive behavioral therapy), diet (probiotics) and percutaneous electrical nerve field stimulation.
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Rome IV diagnostic workflow of FAPDs



Facts



- ❖ Testing for celiac disease by measuring serum tissue transglutaminase antibody and total IgA seems reasonable and should be considered, especially in children with an IBS-D phenotype.
- ❖ Evaluation of fecal calprotectin levels is being increasingly utilized for the non-invasive screening of intestinal mucosal inflammation.
- ❖ The role of *Helicobacter pylori* in children is controversial, although data suggest that *Helicobacter pylori* infections are not associated with FAPDs and its eradication does not correlate with improvement of abdominal pain.

Treatment of child or adolescent IBS

- Dietary changes
- Address and treat psychosocial dysfunction

Ineffective

Predominantly IBS-C vs IBS-D

IBS-C

IBS-D

- Laxatives
- Probiotics
- Cognitive behavioural therapy or other psychological approaches
- Pharmacotherapy, including prokinetics

- Low FODMAP and other diets
- Probiotics
- Antibiotics
- Antidiarrhoeals
- Bile acid binders
- Antispasmodics
- Cognitive behavioral therapy or other psychological approaches

Add or switch

- Novel therapies
- Pain modulation

Add or switch



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