Challenges of Caring for Children with Functional Gastrointestinal Disorders

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Functional gastrointestinal disorders (FGIDs) are a group of disorders of the gastrointestinal tract characterized by the absence of biochemical, structural, or anatomical abnormalities to explain the symptoms. FGIDs are defined by the Rome III criteria and include disorders of defecation (constipation and non-retentive fecal disorders), abdominal pain-related disorders (functional dyspepsia, functional abdominal pain, irritable bowel syndrome, and abdominal migraine), and other less common disorders such as rumination and cyclic vomiting syndrome.

FGIDs are common in children throughout the world. Studies from Colombia and Sri Lanka found that 29% of schoolchildren have FGIDs. The groups of FGIDs associated with abdominal pain are among the most common FGIDs. Although 35% to 38% of schoolchildren report abdominal pain weekly, only 2% to 3% seek medical attention for abdominal pain. Parents report fewer symptoms in their children than children do. Based on parental interview, only 8.1% of parents reported chronic abdominal pain in their children, and only 2.4% could be diagnosed with a FGID. Together the data suggest that parents are less aware of their child’s symptoms and that many children suffer from pain without receiving medical care, as illustrated by the small proportion of children with symptoms who consult their doctor.

RECEIVING MEDICAL CARE

The low ratio of medical care cannot be explained by the benign and transient nature of the symptoms. Children with FGIDs have a lower quality of life, as well as higher anxiety and depression scores. Adults with a history of FGIDs as children have more psychiatric disorders and higher use of psychiatric medications. The low proportion of children with abdominal pain who consult their pediatricians in combination with the insurmountable inability to care for all children with abdominal pain at the doctor’s office calls for creative solutions.

Many children with non-organic conditions could receive early care in schools. Nurses in consultation with children’s pediatricians could provide initial care and refer children with unremitting symptoms. This rational approach to care is confronted by the lack of education on the nature and care of children with FGIDs reported by most school nurses. For example, 81% of school nurses in New Jersey reported that education on chronic abdominal pain was insufficient, and 84% believed communication with medical doctors is poor.

ADDITIONAL CHALLENGES

The challenges of caring for children with abdominal pain-related FGIDs are not limited to the school level. There are approximately 750,000 annual office visits for abdominal pain to the primary pediatrician. Despite the enormity of the problem, there is a paucity of well-
designed clinical trials assessing the efficacy of medications for the treatment of abdominal pain-related FGIDs. Primary care physicians are left to care for these children based on poor scientific evidence, expert opinion, and anecdotal experience. Only a handful of randomized, placebo-controlled clinical trials have been published on children with abdominal pain-related FGIDs. Most of them are small and have important methodological limitations. Only one of these studies has been multicenter and included more than 50 children, and it did not show a beneficial effect of amitriptyline compared with placebo. A large placebo effect found in this study may explain the negative results. Seventy-five percent of children reported some improvement using placebo alone. A possible explanation for the large placebo effect is the reassuring attention received by children and parents during the course of the study. Attention to the child’s problem and reassurance are key in the treatment of FGIDs. There is no substitution for the time invested in the care of children with FGIDs.

Families of children with FGIDs require education, attention, and reassurance that no underlying organic condition is missed, and that a logical explanation for the child’s symptoms exists that does not involve extensive testing. The existence of a brain-gut axis dysfunction and the multiple factors involved in the pathogenesis and pathophysiology of FGIDs should be thoroughly explained. Budgetary constraints and increasing time limitations derived from caring for many children daily conspire against providing the best care that children and families with FGIDs deserve. It is our responsibility to educate health care authorities about the challenges of caring for this group of children and the long-term effects that may result from the missed opportunity of a timely intervention. Providing education and reassurance while establishing adequate goals and a detailed management plan can only be accomplished through the allocation of sufficient clinical time.

Novel investigations should help better understand the pathogenesis and pathophysiology of this group of common and tasking disorders. Clinical trials should assess the efficacy of some of the common drugs used in daily practice. Accomplishing these goals while research budgets for the investigation of FGIDs are being reduced from their historical already low levels is unrealistic. Greater investment in research may help identifying novel and differential mechanisms that could play a role in this distinct group of children, allowing tailored treatments for each patient. In this edition, we cover the basic aspects of FGIDs in children. We selected a group of some of the most recognized international experts in the field who were invited to present the fundamentals of a mixed group of FGIDs that include some of the most common, along with some poorly recognized and frequently missed FGIDs.

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REFERENCES