

Case Report

Abdominal Pain Revisited

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Abdominal pain is a symptom in a wide spectrum of childhood illnesses. Depending on the age of the child, there is a wide differential for the etiology of abdominal pain, ranging from benign to emergent surgical causes. A complete history can be difficult to obtain from a young patient, making the diagnosis challenging. Management of chronic abdominal pain requires identifying the red flag signs and systematically ruling out organic cause.

Abdominal pain is a symptom in a wide spectrum of childhood illnesses. It very often becomes a primary reason to seek medical help. AP can be broadly divided into acute and chronic. A child with acute abdomen typically presents with short duration of severe abdominal pain with a local or diffuse tenderness while more commonly children experience episodes of intermittent AP, which often resolve spontaneously. In ~10% of children, the pain does not disappear and becomes chronic, affecting daily life significantly. It seems to account for 2% to 4% of all pediatric office visits. Without an organic cause, chronic AP is called “functional” (FAP) [1]. Either situation calls for systematic and analytical clinical decision making. Evaluation starts with eliciting a relevant history.

The character, location and presence of associated symptoms provide clues leading to appropriate testing and also to probable etiology. Hemogram, electrolytes, amylase/lipase and imaging studies are of help when the presentation is acute. USG is a valuable screening tool for diagnosis of cystic lesions, including abscesses, appendicitis in children, and intussusception, as well as adnexal lesions. CT may be a test of choice in appendicular abscess and acute pancreatitis [2]. Plain X-ray and upper gastrointestinal contrast study are very useful in constipation causing abdominal pain and in subacute bowel obstruction. Surgical or medical management depends on the likely or established diagnosis. Severe and cramping pain such as renal colic and pancreatic pain often require narcotic analgesics, but should not be administered without sufficient evidence for the diagnosis [3].

J Apley defined RAP as the “occurrence of three or more episodes of abdominal pain of such severity as to interfere with a

child’s normal activity over a 3-mo period.”However, the AAP and NASPGHN in 2005 recommended that the term “recurrent abdominal pain(RAP)” should be replaced by a more appropriate term “chronic abdominal pain”, which is defined as long lasting intermittent or constant abdominal pain that is functional or organic (disease-based) [4].

Several etiological studies in India have recognized intestinal parasitic infections, including giardiasis, as the leading cause for chronic abdominal pain. Other common organic causes include chronic constipation, gastroesophageal reflux disease (GERD), food intolerance (e.g. lactose maldigestion, fructose/sorbitol malabsorption), celiac disease, dysmenorrhea, diseases of the urinary tract, chronic inflammatory bowel disease (Crohn’s disease, ulcerative colitis, indeterminate colitis), peptic ulcer disease (in *Helicobacter pylori* infection), pancreatitis and hepatobiliary diseases.

Management of chronic abdominal pain requires identifying the red flag signs and systematically ruling out organic cause. “Red flags” on history and physical examination include localized pain away from the umbilicus, loss of weight or growth retardation, pain awakening the child at night, organomegaly, arthritis, pallor, pain associated with changes in bowel habits, dysuria, rash, repeated vomiting, especially bilious, constitutional symptoms like recurrent fever, loss of appetite, lethargy and family history of inflammatory bowel disease [5]. Elevated ESR and/or CRP and Upper and lower endoscopy should be considered in adolescents with persistent abdominal pain and presence of blood in stools. Inflammatory bowel disease, eosinophilic gastroenteritis, bleeding peptic ulcer, atypical colitis and Solitary Rectal Ulcer Syndrome are some examples of endoscopic diagnosis. Newer diagnostic modalities like MRCP for chronic pancreatitis and MR enterography for IBD may also be used judiciously. Once organic cause is ruled out by appropriate clinical and lab workup. It is important to diagnose FGID by using Rome iii criteria and avoid psychological labeling. There have been few studies of the treatment of functional abdominal pain in children. There is inconclusive evidence that a lactose-free diet decreases symptoms or that a fiber supplement decreases the frequency of pain attacks. There is inconclu-

sive evidence of the benefit of acid suppression with H2-receptor antagonists to treat children with dyspepsia. There is evidence that treatment for 2 weeks with peppermint oil may provide benefit in children with IBS. There is also evidence that cognitive behavioral therapy may be useful in improving pain and disability outcome in the short term [6,7].

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