Recurrent Abdominal Pain Pathway

Clinical assessment / management tool for Children with **recurrent/chronic** abdominal pain
(For **acute** abdominal pain use alternative pathway)

Management – Primary Care and Community Settings

Most children with recurrent episodes of abdominal pain have a functional cause (see page 2 for different types)

Green – Low risk

- Pain ill-defined and poorly localised or around belly button
- May be associated with fatigue and/or headaches
- Can be worse around stress
- Minimal impact on usual activities, normal school attendance
- Pain typically brief (<1hr) and resolves spontaneously
- No red or amber features

Green Actions

- Go through patient advice sheet
- Address any constipation
- Explore psychosocial factors and consider signposting for support (HEEADSSS screen in teenagers)
- Encourage parents/child to keep a symptom diary
- Encourage conservative strategies; limit analgesia use to 3 days a week
- Consider trial of mebeverine or peppermint oil in older teenagers.

Amber – Intermediate risk

- Involuntary weight loss or dropping through centiles
- Chronic diarrhoea*
- Frequent vomiting
- Joint swelling/redness/pain
- Persistent or recurrent sores around mouth or bottom
- Nocturnal diarrhoea (Fam. hx of IBD?)
- Delayed puberty
- Significant reduction in school attendance.

*but consider toddler's diarrhoea

Amber actions

- Ensure Green actions completed
- Consider baseline investigations (FBC, U&E, CRP, coeliac screen, +/-faecal calprotectin)+
- Seek advice from / make routine referral to general paediatric team.

+ Calprotectin should only be undertaken for chronic symptoms and is more sensitive and specific in adolescents and if the result is >700mg/kg. The normal range is much wider for <4y olds and children having enteral feeds.

Red – High risk

(Is this different from previous episodes? Check Obs, urinalysis, blood sugar and ?bHCG)

- Features of sepsis or shock (fever, ↑HR, ↑RR, ↓BP, capillary refill>2 seconds, reduced consciousness)
- Severe tenderness or percussion tenderness
- Abdominal distension with severe pain, bilious vomiting (suggestive of bowel obstruction)
- Testicular pain
- High blood sugar (DKA)
- Jaundice

Red actions

- If features of sepsis or shock: arrange urgent ambulance transfer and alert Children's Emergency Department.
- For other red features: discuss immediately with paediatrician or surgeon on call

Alarm features (→ check acute pathway)

- Recent abdominal trauma or surgery
- Persistent or increasing frequency of vomiting
- Persistent RUQ or RLQ pain
- Sexually active (PID or ectopic?)
- Blood in faeces, vomit or urine
- Polydipsia, polyuria, acute weight loss
- Abdominal mass or hernia

Functional causes of abdominal pain	Criteria
Functional dyspepsia	• Epigastric pain • No change in stool form/frequency • No relief on opening bowels
Irritable Bowel Syndrome	Pain (≥1day/week for ≥3 months) associated with two or more of: • Related to opening bowels • Change in stool frequency • Change in stool form
Abdominal migraine	• Intense episodes of pain lasting >1hr that prevent normal activity • Child well for weeks between attacks • Pain associated with 2 or more of: nausea, vomiting, pallor, photophobia, off food >2 attacks in preceding 12 months. May benefit from treating as per migraine
Functional abdominal pain not otherwise specified	• ≥4 episodes/month for ≥2 months • Does not meet criteria for any of the above diagnoses

Endorsed and agreed by the Wessex Paediatric Gastroenterology Network." with a review date of April 2027

Principles for managing functional abdominal pain: Give a diagnosis following reassuring investigations.

- Seek and address the family's concerns directly. Note that investigations will be normal in 90-95% cases. This does not mean that pain is not real, simply that there is not an underlying disease
- Offer explanation for functional pain, support with resources and reassure that symptoms improve with time
- Place the emphasis on maintaining function/limiting impact on activities rather than eliminating pain.
- Address lifestyle, diet and constipation (see QR code)
- Evidence for PPIs, antacids, antispasmodics and analgesia is poor; distraction is more effective (and addressing any anxiety and explaining 'brain-gut' axis). A diary of symptoms plotted on a month-calendar may help identify stressors.
- Allergy testing is not helpful without IgE-mediated symptoms (i.e. abdominal pain with urticaria, vomiting/lip swelling within 1-2 hours of ingestion). Do not do H.pylori test+treat: refer for endoscopy if symptomatic H.pylori suspected.
- The link between 'food intolerance' and abdominal pain is poor; if the family wish to trial dietary exclusion it is important to keep a food diary throughout and re-challenge after two weeks
- Ultrasound is less likely to be of clinical benefit in the presence of typical features and absence of red flags