Recurrent Abdominal Pain in Childhood

by PD Dr. med. Philip Bufler, Dipl.-Psych. Martina Groß, PD Dr. med. Holm H. Uhlig in volume 17/2011

**Many Causes Are Unknown**

According to the article, chronic functional abdominal pain in children and adolescents is “not due to any organic cause.” As in this article, the entire medical literature maintains a separation between “organic” and “functional” (non-organic). However, functional disorders are pathologies whose etiologies and pathogeneses are not at all understood and for which causal therapeutic approaches are lacking to date. The idea that all medical problems that cannot be identified by using today’s methods are per se non-organic has to be incorrect. The foreseeable result of this attitude among medical professionals is that patients who have no organic illness will inevitably be perceived as mentally or at least psychosomatically ill. It is therefore not surprising that patients feel they are being labeled as hypochondriacs, although “there is no organic disease” (1).

Abolishing the antiquated separation between “functional” and “organic” (non-organic) is well overdue. Instead, a distinction between “organic” and “non-organic” should be made even for functional disorders. This may be diagnostically complicated, but it is urgently needed in view of the existing confusion, so that patients with functional disorders are not treated consciously or unconsciously as primarily mentally ill or psychosomatic patients.

Furthermore, awareness needs to be raised vis-à-vis the fact that many organic causes for functional abdominal pain are currently unknown. Initial pointers exist in the insights into irritable bowel syndrome, whose confirmed causes include chronic infections, or postinfectious causes, or dysbiotic causes (2). I hope that the coming years will bring substantial advances in our knowledge. Up until that time, the treatment of choice, as outlined in the otherwise well conceived article, is the best possible distraction from the symptoms.

**REFERENCES**


**Possible Magnesium Deficiency Should Be Investigated**

Since the existence of polymorphous functional syndromes is the actual clinical correlate of magnesium deficiency (MD), it is almost a “model disorder” for functional impairments—in the past known as “spasmophilia” (France), “neuronal hyperexcitability syndrome” (Italy), or “chronic tetanic syndrome” (German speaking countries). Compared with cerebral (central nervous system, vegetative nervous system, psyche), cardiovascular and muscular-tetanic forms of MD, the abdominal-visceral form dominates in children—depending on age—but was not mentioned by Bufler et al in their article (1).

The Rome III classification puts functional abdominal pain into the H-subgroup (1) (eTable 1). As “functional abdominal syndrome/FAS” (according to Heinisch), 46% of such disorders manifest in children with several functional syndromes (2). A positive von-Bonsdorff-test in 69% does not differentiate these children significantly from genuine hyperventilation tetany patients (2), in whom MD is well documented (3). The effectiveness of magnesium treatment in >90% does not only affect the episodic symptoms in this group but also associated FAS, similar to the way in which children with FAS benefit from magnesium treatment (4).

Since the Rome III criteria allow the term “functional” only if the pain “cannot be accounted for by any structural or biochemical disease” (1), the criterion “no evidence for .... metabolic ... process” (subgroups H1a, H2a–H2d) exclusively contradicts the categorization of “isomorphous” symptoms of FAS in MD among the Rome III-H-subgroups; none the less they are functional disorders. In order to evaluate these diagnostically, the diagnosis of MD, which was not mentioned, is required; in order to treat the deficiency, treatment with sufficient magnesium is required. To focus on cognitive behavioral therapeutic measures as the only therapeutic approach should therefore not be a learning objective.

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Fecal Biomarkers

As a German pediatrician and pediatric gastroenterologist who lives in Norway, I read the article by Bufler et al. with great interest. Recurrent abdominal pain is an everyday phenomenon in pediatric consultations, in the individual practice as well as in the context of a second opinion in hospital. In Norway, fecal calprotectin measurement has been used as a routine biomarker for gastrointestinal (GI) inflammation since 2000. Calprotectin is particularly useful for distinguishing between organic and functional pathogenesis of recurrent GI symptoms, as functional GI symptoms do not elevate calprotectin levels above normal. As mentioned by Bufler and colleagues, fecal calprotectin is also among the primary diagnostic tools for chronic recurrent GI symptoms in Norway (1). One advantage is that the parents can be reassured if the measurement is negative (which is an important component in functional GI symptoms). Furthermore, if the calprotectin test result is negative, endoscopy has to be undertaken in a tiny minority of cases—namely, those patients in whom the suspected pathogenesis is other than inflammatory. In other words, using calprotectin helps reduce endoscopies in children with chronic GI symptoms to the lowest possible number.

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Dr Dorlöcher has received honoraria and expenses from Bühlmann Diagnostics.

SEXUAL ABUSE

I wish to point out that one differential diagnostic perspective on abdominal pain is that of sexual abuse. A (fictitious) example:

A middle aged woman reports that she suffered from abdominal pain for almost all of her childhood. In adulthood, she had undergone many investigations, and no organic correlate had been identified. Only now did she feel confident enough to speak out about the fact that she had been frequently sexually abused since her 5th year of life. Her symptoms are slowly disappearing while she is receiving psychotherapy.

Abdominal pain is certainly no definite indication of abuse, but can be a pointer.

There is neither detailed literature on this subject nor are there study materials (1). The materials that exist repeatedly point out that abdominal pain can be a symptom of sexual abuse (2).

Such symptoms are easy to understand even when merely thinking about the fact that stress, for example, can cause abdominal pain. Eating disorders and especially functional gastrointestinal disorders (3), which cause abdominal symptoms, also seem to indicate an association with experiences of abuse.

Current data show that further research is needed. This is of particular importance since research findings on the topic of symptoms of abuse, combined with differential diagnostic considerations, have direct effects on the diagnostic evaluation, prevention, and treatment of abdominal pain.

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The author declares that no conflict of interest exists.

EXAMINE THE EYES

In their article the authors report a common syndrome of therapy resistant, migraine-like abdominal pain in childhood, whose causes remain vastly unidentified and whose therapeutic success is mostly sought in a psychosomatic approach. The frequent involvement of the eyes in this syndrome is not mentioned, even though a direct circuit exists between the areas of the nuclei of the ocular muscles, the vestibular organs, the cerebellum, and the vegetative centers in the diencephalon, from which biologically eyes developed. If the cooperation between the eyes is disrupted, diplopia results with substantial asthenopic symptoms, headache, and abdominal pain. Correcting visual impairment by correcting the visual defects such as hyperopia, myopia, astigmatism, especially the associated heterophoria (commonly known as “angle” visual defect), by using prismatic spectacles according to the measuring and correcting method after Haase in the Polatest may help. The symptoms mentioned above