Paediatric GI Gems

April 16th 2015

Paediatric GI Gems

- Most children will have some ‘GI’ or ‘abdominal’ symptom
- Most of these do not need referral
- Almost all in need of referral can be referred to a General Paediatrician initially

Constipation/soiling

Background

A problem, not a disease
Manageable in primary care
Investigations rarely if ever needed
Rectal therapies strongly discouraged
Longterm (>>6 months) stool softeners usually required
Avoid blame/punishment
Relapse common
Adequate motivation & consistent approach essential
Child/parent to take responsibility for their own management;
Pitfalls: inadequate bowel clearout; Under dosing/premature cessation of meds; poor compliance

History

- Hard, infrequent stools
- +/- haematochezia /chezalgia
- +/- overflow/ staining
- ? Previous wide calibre stools
- Stool withholding behaviours
- Stressful on child, family

? underlying factors– CP /Spina bifida / muscular dystrophy

Extra Fibre
- Limited evidence, slightly better than placebo in children

Extra Fluid
No evidence of benefit in children

Pre/Probiotics
Not beneficial

Examination

- **General physical exam**
- ?Palpable stool masses
- **Anal Inspection (NOT digital rectal exam)**
  - -?Anal position/natal cleft normal
  - -?soiling evident
  - -?skin tags/ tears/ fissures/ sphincter laxity/ inflammation eg perianal Strep infection

Red Flags-consider referral to local general paediatrics

Delayed meconium passage >24h
Failure to thrive
Indolent constipation from birth
Large(>5mm) fleshy perianal tags
Deep perianal fissures
Other stigmata of IBD

Investigations

- Blood and radiology tests are **not** indicated

Treatment

1. **Disimpaction**- stimulants or high dose PEG3350
   REPEAT in regular cycles initially, then PRN
2. **Maintain soft daily stools** - "toothpaste consistency"
3. **Regular sitting once trained**

- Motivation + support are key
- Long-term softeners, wean slowly
- Titrate doses up/down to achieve desired stool consistency

STIMULANTS
- Bisacodyl: once daily x 3-5 days
- Picosulphate: daily for 3-5 days
- Senna: daily

-Monotherapy preferable

SOFTENERS
- PEG 3350 – (titrate dose)
- Liquid Paraffin (not <1yr or if aspiration risk)
- Lactulose (mainily if <1yr)

References

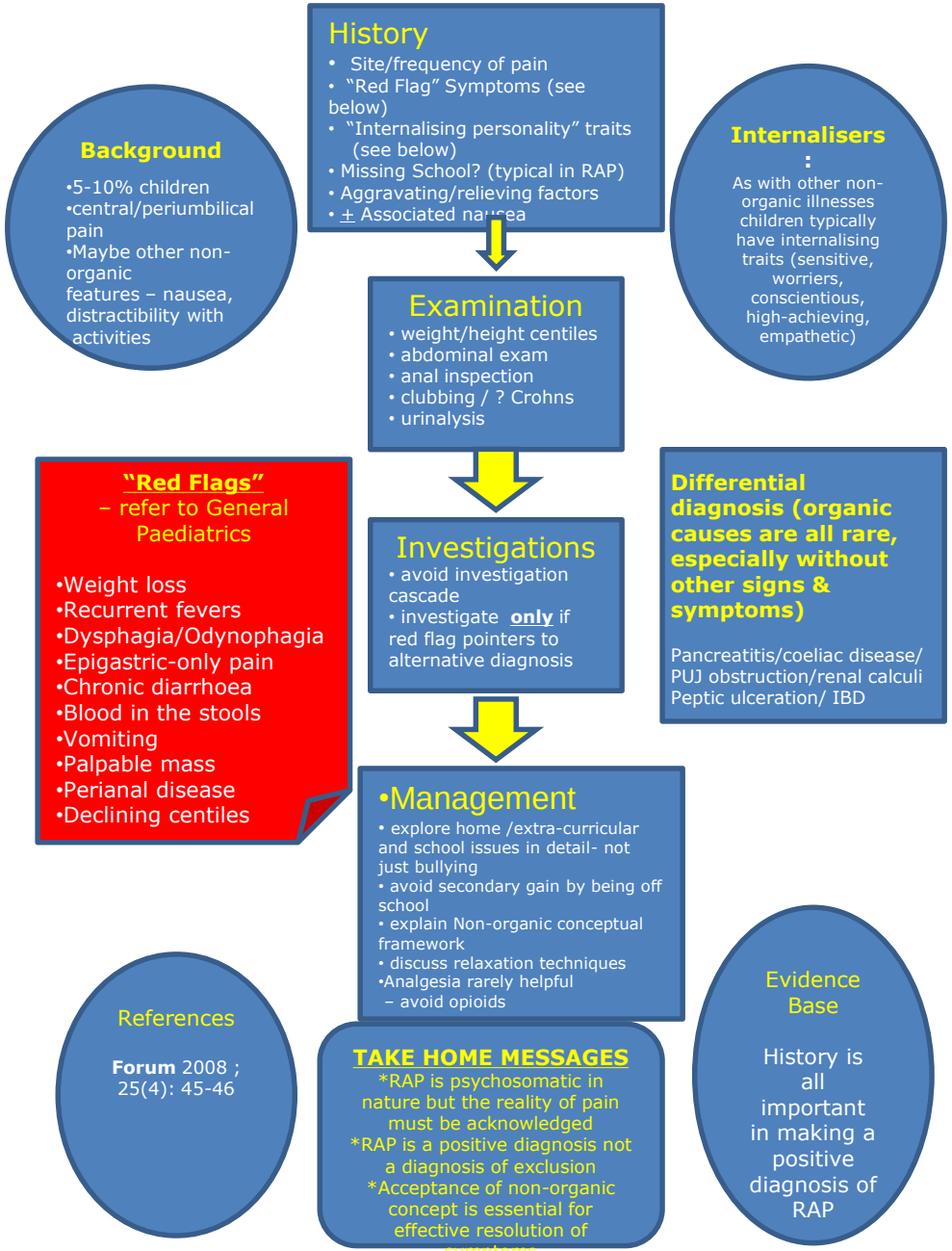
NICE CG 99 201
Paris Consensus
J *Pediatr Gastroenterol Nutr* 2005 ;40(3): 273-5

Pediatrics. 2011; Oct; 1 Oct;128(4):753-61

TAKE HOME MESSAGES

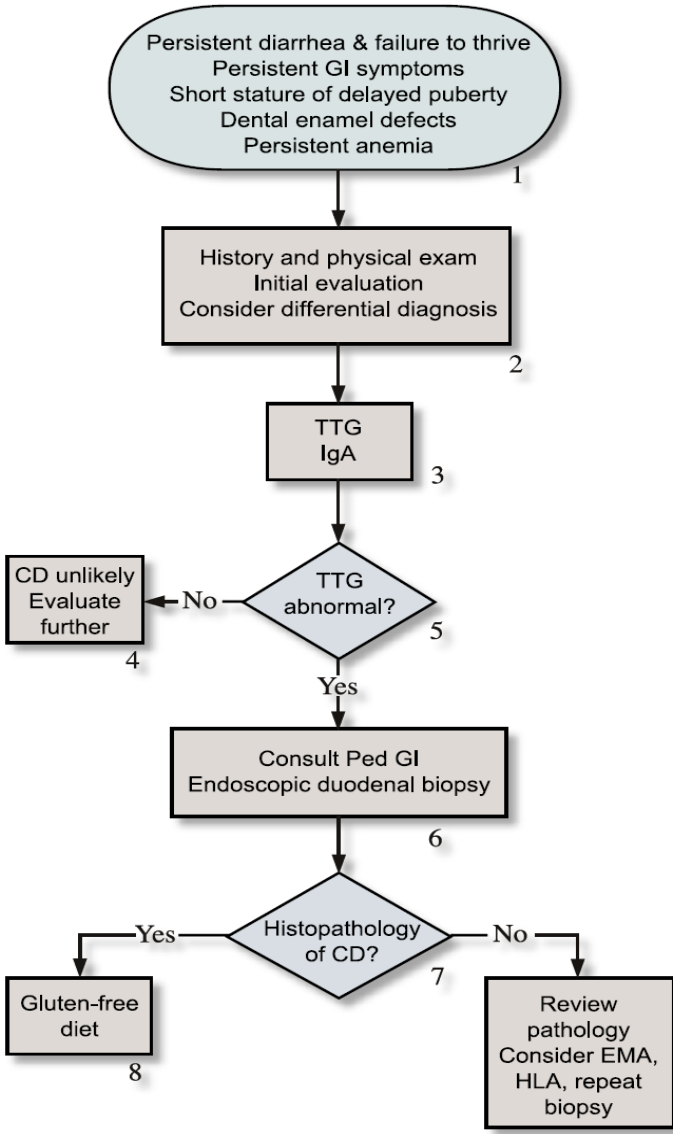
Manageable in primary care
Is a marathon and not a sprint
Rarely requires investigation/referral
Preferably single agent stimulant and softener
Children may need 'adult' doses of softeners/ stimulants

Non-Organic Recurrent Abdominal Pain

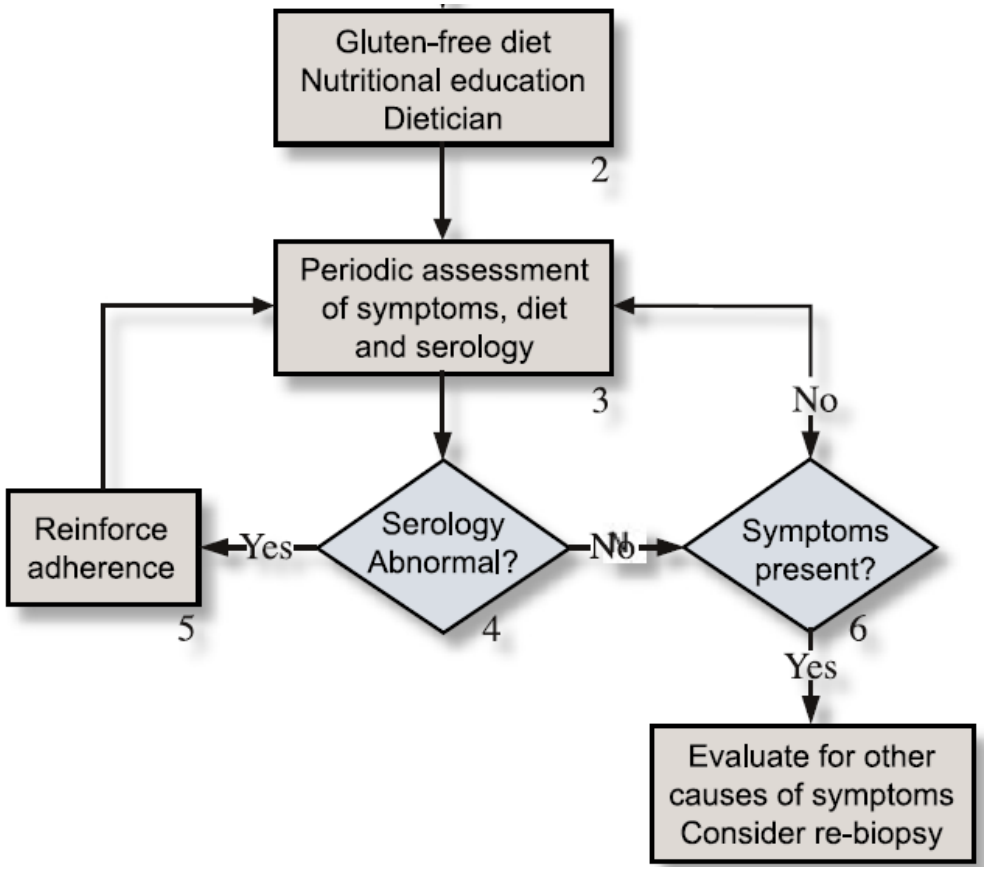


Paediatric coeliac disease

Symptomatic patients



Management post diagnosis



Irish Educational Video link

http://www.wideo.co/view/4018431416342804919-suzies-story

Aerophagia

Table 1. Identification of a patient with aerophagia based on the Rome III Criteria for FGIDs [4]

Aerophagia
Must include at least two of the following:
– Air swallowing
– Abdominal distension because of intraluminal air
– Repetitive belching and/or increased flatus

Table 2. Clinical evaluation of patients with aerophagia

Suggestive history	bloating, belching, flatulence, distension, constipation, abdominal pain, no vomiting; history of trigger stressful events
Physical examination	regular growth curve, increased tympany over the abdomen, normal bowel sounds, no signs of ileus or other alarm signs

Reassurance

Habit reveral

Avoid fizzy drinks, chewing gum, drinking with straws etc

Paediatric rumination

Table 1 | Rome III definitions of rumination syndrome in adults, adolescents and infants

Rumination syndrome in adolescents
Must include all of the following:
(i) Repeated painless regurgitation and re-chewing or expulsion of food that
a. begin soon after ingestion of a meal
b. do not occur during sleep
c. do not respond to standard treatment for gastro-oesophageal reflux
(ii) No retching
(iii) No evidence of an inflammatory, anatomic, metabolic, or neoplastic process that explains the subject's symptoms
Rumination syndrome in infants
Must include all of the following for at least 3 months:
(i) Repetitive contractions of the abdominal muscles, diaphragm and tongue
(ii) Regurgitation of gastric content into the mouth, which is either expectorated or re-chewed and re-swallowed
(iii) Three or more of the following:
a. Onset between 3 and 8 months
b. Does not respond to management for gastro-oesophageal reflux disease or to anticholinergic drugs, hand restraints, formula changes and gavage or gastrostomy feedings
c. Unaccompanied by signs of nausea or distress
d. Does not occur during sleep and when the infant is interacting with individuals in the environment

Majority of patients have other symptoms – nausea, heartburn, abdominal discomfort, diarrhoea, weight-loss etc

May persist for hours post-prandially

Treatment mainstays:

- PPI (dental protection)
- Good dental hygiene, esp post rumination
- Habit reversal techniques:
    - abdominal breathing- place hand on chest and abdomen; only hand on abdomen may move during breathing
    - chewing gum

Aliment Pharmacol Ther 2011; 33: 782-788

Potential Referrals

Direct to Paediatric Gastroenterology

Tertiary GI conditions including:

- Highly suspicious/likely IBD
- blood PR plus other 'red-flag' signs/symptoms – large vol/anaemia etc
- coeliac disease
- conjugated hyperbilirubinemia (non-infectious)
- abnormal liver enzymes (miscellanous causes)
- newly suspected/identified clinical portal hypertension
- pancreatic problems (pancreatitis, pancreatic insufficiency)
- eosinophilic oesophagitis
- recurrent food impaction, severe dysphagia
- Haematemesis
- chronic diarrheoa (not toddler's diarrheoa)
- familial/genetic GI conditions (incl Peutz Jegher's Syndrome, FAP etc);
- refractory anaemia etc.

Direct to General Paediatrics

- Constipation and/or soiling not responding to guidelines
- Recurrent abdominal pain
- chronic nausea
- Potentially functional symptoms- rumination, flatus, malodour etc
- ?Toddler's diarrhoea
- ?IBS
- GOR
- 'failure to thrive'
- ?food allergies/food intolerance;
- Infants/children with behavioural issues – poor sleeping/feeding/crying habits
- Rumination; excessive belching/flatus/foul smelling breath/foul flatus;
- unconjugated hyperbilirubinaemia
- any uninvestigated ?disease - e.g. ?coeliac without tTG + IgA, ?FTT or ?malabsorption without centile chart documenting falling centiles; etc.