CHRONIC ABDOMINAL PAIN REFERRAL GUIDELINE

MAINE MEDICAL PARTNERS - PEDIATRIC SPECIALTY CARE (DIV. OF GASTROENTEROLOGY) • 887 CONGRESS ST, SUITE 320, PORTLAND, ME • (207) 662-5522

HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

Bilious emesis

Significant weight loss > 10%

Jaundice

Bloody diarrhea/Bloody emesis

Surgical abdomen

Mass

Perirectal disease

SUGGESTED PREVISIT WORKUP

CBC, CMP, CRP, total IgA, TTG IgA (if < 2 yo add anti deamidated gliadin IgG)

Fecal calprotectin

Abd ultrasound

Stool Culture/Sensitivities

Stool for C diff toxins or PCR

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

Reflux symptoms

Nausea/ Non bilious emesis

Chronic abdominal pain with normal weight gain

SUGGESTED WORKUP

CBC, CMP, CRP, total IgA, TTG IgA (if < 2 yo add anti deamidated gliadin IgG)

Consider treatment based on symptoms (Miralax, ranitidine)
- Miralax- titrate to soft stool
- H2 blockade
- Consider PPI u to 2 mg/kg/day/BID

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

Intermittent pain that does not interfere with activities

Pain does not wake from sleep

Continued weight gain

Intermittent bloating

SUGGESTED MANAGEMENT

Strict lactose free diet or Lactaid pills as directed

Consider treatment based on symptoms (Miralax, ranitidine)
- Miralax- titrate to soft stool
- H2 blocker

CLINICAL PEARLS

- Scoop on Poop link – see constipation guidelines.
- A trial of empiric Proton Pump Inhibitor (PPI) is reasonable but should not be continued longer than 10-12 weeks without an evaluation by a GI specialist for inflammatory processes treated by acid suppression or assessment of erosive esophagitis.
- The vast majority of chronic abdominal pain is functional – strongly consider addressing co-morbid psychosocial contributors. It is helpful if the PCP has initiated this discussion with families.

Maine Medical PARTNERS

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.

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