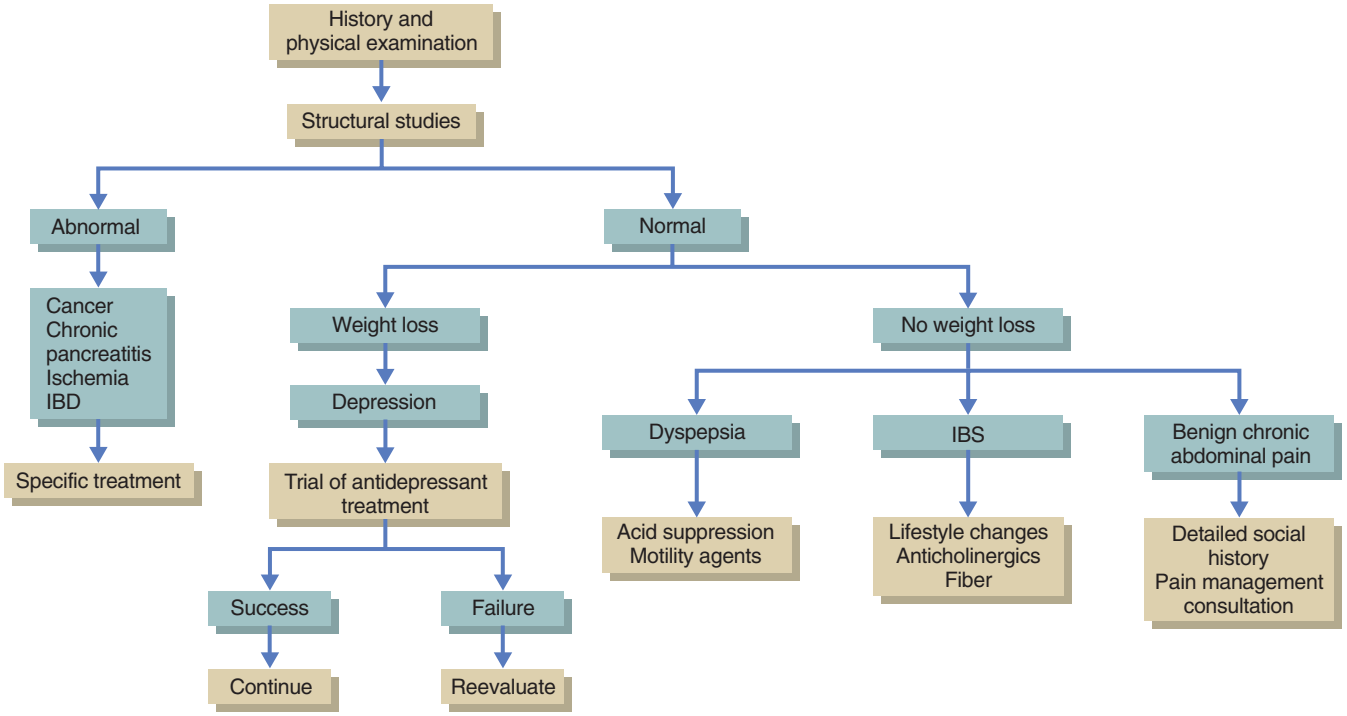

FIGURE 33-1 Approach to the patient with chronic abdominal pain. IBD, Inflammatory bowel disease; IBS, irritable bowel syndrome.

effective strategy for the treatment of dyspepsia when *H. pylori* organisms are found in the absence of peptic ulcer disease.

Irritable bowel syndrome (IBS) is a very common disorder. Estimates are that 15% of Americans suffer from IBS on a regular basis and that 40% to 50% of referrals to gastroenterologists are related to IBS. The syndrome consists of abdominal distention, flatulence, and disordered bowel function. The abdominal pain of IBS tends to be in the left lower quadrant, but it can be located elsewhere or be more generalized. Any patient with weight loss, anemia, nocturnal symptoms, steatorrhea, or onset of symptoms after age 50 years should be evaluated carefully for organic disease because these symptoms are not associated with IBS.

The Rome criteria, developed for research studies, may be helpful in the diagnosis of IBS. These criteria include pain that is associated with change in bowel habits, relieved with defecation, or accompanied by distention or bloating. Patients are reassured, counseled, and treated with anticholinergic agents and stool softeners. Although serotonin (5-HT) agonists such as alosetron and tegaserod showed promise initially, they have been relegated to limited use due to unacceptable side effects. Linaclotide is a new agent for chronic constipation and IBS with constipation (IBS-C). This medication causes increased secretion of chloride and bicarbonate into the intestinal lumen via a cyclic guanosine monophosphate (cGMP) pathway. This pathway also may be responsible for relief of visceral pain in patients with IBS-C.

The more challenging clinical problem is *functional abdominal pain syndrome*. This term describes a condition in which the pain has been present for months or years. The complaints of pain often are not related to eating, defecation, or menses, unlike other causes of chronic pain. The patient is most likely to be a woman who has undergone numerous examinations and diagnostic studies with negative findings and, in many cases, surgical operations without any relief. Lengthy or repeated diagnostic work-ups are counterproductive and only convince the patient that one more test is what is needed to determine the source of the pain. The physician must establish that organic disease is not present and must also realize that the pain is real. These patients are not malingerers despite the fact that the pain does not fit any familiar pattern. Depression may be the result rather than the cause of the pain.

Management of chronic abdominal pain is demanding and requires as much tact, diplomacy, and compassion as scientific knowledge. An effort should be made to inquire about social factors, including history of physical and sexual abuse, particularly in women. Psychiatric evaluation may be necessary, but the suggestion for such a consultation may be interpreted by the patient as evidence that the physician believes "the pain is in my head." Referral to a competent pain management specialist is helpful in some cases. This approach offers the possibility of providing relief with nerve blocks if the pain is localized or with other pain-relieving devices. If this approach fails, referral to a psychologist or psychiatrist may be acceptable to the patient.

The algorithm in Figure 33-1 presents a practical approach to chronic abdominal pain.

For further information, please see Chapter 137, "Functional Gastrointestinal Disorders," in Goldman-Cecil Medicine, *25th Edition.*