Functional Abdominal Pain - Summary Clinical Guideline

Reference No: CG-GASTRO/2019/025

Introduction

We are currently seeing a large number of patients with functional abdominal pain admitted to hospital and they are remaining as inpatients for prolonged periods of time. Some may have been previously given a diagnosis of EDS3 (Ehlers Danlos Syndrome variant 3), for which there is no diagnostic test. Some of these patients have underlying psychological problems however their care is being led by gastroenterologists who are investigating and assessing their physical symptoms.

The following points should be considered:-

1. Each patient should have a lead medical Gastroenterology Consultant who is responsible for their ongoing care.
2. The management should be in the outpatient clinic, and if criteria are met this should be in the CoGS (Complex Gastrointestinal Symptom) clinic, held on Wednesday mornings
3. These patients should be investigated as appropriate in the same way as patients with irritable bowel syndrome are investigated. However, once investigations have been complete, no further investigations should be organised without careful consideration.
4. It should be explained to patients that they have functional abdominal pain and this has a psychiatric/psychological component. The avoidance of labelling and the use of a formulation constructed with the patient is encouraged. This is a narrative diagnosis taking into account other social and medical complexities and can also acknowledge positive aspects including the patients coping skills.
5. The use of the term Ehlers Danlos Syndrome should be avoided unless the patients have "traditional" Ehlers Danlos Syndrome. The preferred term of hypermobility with functional GI problems should be used. Where a diagnosis is being pursued we should only offer review by our own Derby rheumatology team.
6. The sitting of a feeding tube (NG or NJ) should only take place after an MDT discussion. This would include review of the patients BMI, targets for weight gain and a plan for removal.

7. Opiate analgesia should be avoided. Where patients are already established on opiates these should be withdrawn either as an inpatient or as an outpatient. IV paracetamol is the preferred analgesic in an acute setting
8. Patients who have been seen in the CoGS clinic will all have a front sheet, detailing key points from the history, a drug list and management aims. These can be found in the CoGS file on the shared drive.
9. During an inpatient stay ward based consultants would be encouraged to come to the 12.30-1.30pm reflection at the end of CoGS clinic to link with the outpatient team. This happens once a month and is a CoGS MDT with consultant, nurse psychologist and dietician. Emailing Helen Gibbs on helengibbs@nhs.net prior to coming down would be helpful, to allow time.
10. Inpatients may request to change consultant. The mechanism for undertaking this should be that the patient and family should undertake a meeting with the consultant who has been allocated to care for them on the ward or in outpatients. There may be issues which need to be addressed and this may be the preferred approach rather than simply "changing consultants". If the nursing staff are approached about this they should ask the patients to speak directly to their current consultant.
11. We acknowledge the difficulty in delivering care to this group of patients and their families for all members of staff involved. We as a gastroenterology department strongly support the need for regular supervision of staff, the need to debrief safely, and subscribe to the long term vision of a department of psychological medicine. This will deliver the biopsychosocial treatment we believe is required whilst safeguarding the well bring of the clinical teams providing this.