Nonpharmacologic Treatment of Functional Abdominal Pain Disorders: A Systematic Review

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abstract

BACKGROUND AND OBJECTIVE: Various nonpharmacologic treatments are available for pediatric abdominal pain–related functional gastrointestinal disorders (AP-FGIDs). Data on efficacy and safety are scarce. The goal of this study was to summarize the evidence regarding nonpharmacologic interventions for pediatric AP-FGIDs: lifestyle interventions, dietary interventions, behavioral interventions, prebiotics and probiotics, and alternative medicine.

METHODS: Searches were conducted of the Medline and Cochrane Library databases. Systematic reviews and randomized controlled trials (RCTs) concerning nonpharmacologic therapies in children (aged 3–18 years) with AP-FGIDs were included, and data were extracted on participants, interventions, and outcomes. The quality of evidence was assessed by using the GRADE approach.

RESULTS: Twenty-four RCTs were found that included 1390 children. Significant improvement of abdominal pain was reported after hypnotherapy compared with standard care/wait-list approaches and after cognitive behavioral therapy compared with a variety of control treatments/wait-list approaches. Written self-disclosure improved pain frequency at the 6-month follow-up only. Compared with placebo, Lactobacillus rhamnosus GG (LGG) and VSL#3 were associated with significantly more treatment responders (LGG relative risk: 1.31 [95% confidence interval: 1.08 to 1.59]; VSL#3: P < .05). Guar gum significantly improved irritable bowel syndrome symptom frequency; however, no effect was found for other fiber supplements (relative risk: 1.17 [95% confidence interval: 0.75 to 1.81]) or a lactose-free diet. Functional disability was not significantly decreased after yoga compared with a wait-list approach. No studies were found concerning lifestyle interventions; gluten-, histamine-, or carbonic acid–free diets; fluid intake; or prebiotics. No serious adverse effects were reported. The quality of evidence was found to be very low to moderate.

CONCLUSIONS: Although high-quality studies are lacking, some evidence shows efficacy of hypnotherapy, cognitive behavioral therapy, and probiotics (LGG and VSL#3) in pediatric AP-FGIDs. Data on fiber supplements are inconclusive.
Abdominal pain–related functional gastrointestinal disorders (AP-FGIDs), diagnosed according to the Rome III criteria, are defined as chronic or recurrent abdominal pain, not explained by underlying organic disorders.1 AP-FGIDs affect ~20% of children worldwide and include functional dyspepsia, irritable bowel syndrome (IBS), abdominal migraine, functional abdominal pain (FAP), and functional abdominal pain syndrome.1,2 AP-FGIDs have a significant impact on children and adolescents’ quality of life, daily activities, and school absenteeism and can have long-term psychological implications.3 Moreover, patients with AP-FGIDs are at risk for continued symptoms in adulthood, and the costs are substantial.4–6

Standard medical care consists of reassurance, education, and dietary advice.7 Despite ongoing efforts to identify causal and contributing factors in AP-FGIDs, successful management is complicated by an incomplete pathophysiologic understanding of the disorders. The biopsychosocial model, based on a complex interplay of genetic, physiologic, and psychological factors, is conceptualizing the etiology of FGIDs.

It is hypothesized that pediatric AP-FGIDs are strongly associated with stress and psychological disorders such as anxiety and depression,8 wherein the coping potentials of children with AP-FGIDs are low compared with those of healthy children.9 Therefore, interventions such as cognitive behavioral therapy (CBT), hypnotherapy (HT), and yoga aim to teach alternative responses to stress.10 Systematic reviews have concluded that CBT and HT offer beneficial effects for children with AP-FGIDs.11,12

The role of food in FGIDs has been revisited recently in the adult literature.13,14 Food may trigger symptoms in FGID patients who already have physiologic alterations, subsequently making them susceptible for hypersensitivity.13 However, recognizing which specific food components trigger symptoms is difficult and can lead to a profusion of investigations and dietary therapies, largely based on expert opinion.14 Two previous systematic reviews reported that fiber supplements are ineffective in treating AP-FGIDs, whereas conclusions were contradictory regarding probiotics.15,16 Treatment of children who have AP-FGIDs can be challenging, especially because high-quality evidence for pharmacologic interventions is lacking.17 Although several systematic reviews summarizing different nonpharmacologic interventions exist,11,15,18 the present systematic review provides an up-to-date overview regarding the efficacy and safety of all nonpharmacologic treatments for pediatric AP-FGIDs. Such a comprehensive and recent overview is warranted.

METHODS

Literature Search

The Cochrane Library and Medline databases were searched for systematic reviews and randomized controlled trials (RCTs) from inception to October 2013. Search terms used items related to pediatric AP-FGIDs and various nonpharmacologic treatments. To identify additional studies, reference lists of reviews and included studies were searched by hand. The full search strategy and key words are available from the authors.

Study Inclusion

Two authors (L.M.A.J.V. and M.M.T.) independently assessed the eligibility of all abstracts. In cases of disagreement, consensus was reached through discussion. Inclusion criteria were: (1) study was a systematic review or RCT; (2) study population comprised children aged 3 to 18 years; (3) diagnosis of recurrent abdominal pain (RAP), FAPS, IBS, functional dyspepsia, or abdominal migraine as defined by the authors; (4) interventions were lifestyle advice such as physical exercise, dietary interventions (fiber supplements; lactose-, gluten-, histamine-, and carbonic acid–free diets; and fluid intake), behavioral interventions such as HT and CBT, prebiotics and probiotics, and alternative medicine (acupuncture, homeopathy, mind–body therapy, musculoskeletal manipulations such as osteopathic and chiropractic manipulations, and spiritual therapies such as yoga); (5) the intervention was compared with placebo, no treatment, any other nonpharmacologic treatment, or a pharmacologic agent; and (6) outcomes were abdominal pain intensity and/or frequency, quality of life, functional disability (eg, school absence), and adverse effects.

Exclusion criteria were: (1) treatment arm with <10 patients; and (2) language other than English. Potentially relevant studies and studies in which the title and abstract provided insufficient information were retrieved as full-text articles.

Quality Assessment and Data Extraction

Two authors (L.M.A.J.V. and M.M.T.) independently rated the methodologic quality of the included studies by using the Cochrane risk of bias tool. For each outcome, quality of evidence was assessed by using the GRADE approach and was categorized as very low, low, moderate, or high.19–21

The same authors extracted data from included studies by using structured data extraction forms containing items on participants, study setting, interventions, and outcomes. Disagreements were resolved through consensus or by a third reviewer (M.A.B.).

Data Analysis

Dichotomous outcomes were analyzed as odds ratios (ORs) or
relative risk (RRs) along with 95% confidence intervals (CIs). For continuous outcomes, the mean differences (MDs) with 95% CIs were reported. Heterogeneity was quantified by using $\chi^2$ tests and the I² statistic, which can be interpreted as the percentage of the total variation between studies that is attributable to heterogeneity rather than chance. A value of 0% indicates no observed heterogeneity, whereas larger values show increasing heterogeneity. If heterogeneity was not revealed, results of the fixed effect model are presented. If there was substantial heterogeneity (>50%), the random effect model was used.

RESULTS

A total of 568 potentially relevant articles and abstracts were identified (Fig 1). After removal of duplicates ($n = 316$) and screening of abstracts ($n = 210$), 42 full-text articles were assessed for eligibility. Twenty-nine articles were excluded because of the following: adult study population ($n = 6$), irrelevant outcome measures, such as improvement in rectal sensitivity or gastrointestinal symptoms without abdominal pain ($n = 2$), no systematic review or RCT ($n = 15$), or inclusion only of trials that were already included by another systematic review ($n = 6$). Thirteen articles remained for analysis: 7 systematic reviews and 6 RCTs. Two included trials concerned follow-up studies, which will be discussed by using their original studies.

Two systematic reviews included studies with <10 patients per treatment arm, and these studies were therefore excluded.

Data of 1390 children aged 3 to 18 years were included for analysis. Sample sizes ranged from 21 to 200, and follow-up varied from 2 weeks to 5 years. Four trials investigated fiber supplements compared with placebo, and 2 trials studied a lactose-free diet. Four trials investigated probiotics and 3 trials compared HT versus standard care or a wait-list. Seven studies compared CBT with standard care, physiotherapy, fiber supplements, biofeedback, and/or parental support. One trial compared yoga with a wait-list, and 1 trial evaluated written self-disclosure in addition to standard care.

No studies were included on lifestyle advice or prebiotics. A range of different outcomes were measured, and even if the same outcome was measured, different measurement instruments were used. All trials measured abdominal pain as the primary or secondary outcome.

Nine studies reported disability or school absenteeism. Four studies assessed quality of life, and 8 studies assessed adverse effects. Data of 3 studies were pooled to perform a meta-analysis of the efficacy of fiber supplements and 3 studies were used to perform a meta-analysis on probiotics.

Methodologic Quality

The overall quality of evidence was very low to moderate. The Supplemental Appendix displays the GRADE evidence profiles.

Concealment of allocation was unclear in 6 studies. Due to the nature of HT, CBT, WSD, and yoga, blinding was not possible for the caregiver or patient. Dropout was considerable in 4 studies or vaguely described in 3 others. Two studies excluded patients due to poor compliance.

The method of randomization was unclear in 3 studies. Alfvén and Lindstrom provided no information on outcome blinding or treatment duration. Six trials did not present results with absolute numbers and were therefore not included in the meta-analysis. Analyses for follow-up were uncontrolled for baseline differences by Levy et al. Because participants were recruited through physician referral and flyers, these patients were therefore seriously motivated, which can cause bias.

Dietary Interventions

No studies were included evaluating gluten-, histamine-, and carbonic acid–free diets or fluid intake.

Fiber Supplements

Two systematic reviews including 3 RCTs and 1 RCT evaluated the efficacy of fiber supplements compared with placebo for RAP. A systematic review by Huertas-Ceballos et al included 2 RCTs, involving 92 children aged 3 to 15 years. Children received fiber supplements for 6 weeks. No information was available regarding daily fiber intake before and/or during intervention weeks.

Information about abdominal pain was collected through the use of diaries, but the authors did not clarify how these diaries were analyzed. The systematic review by Horvath et al included a third trial with 90 children.
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<td>Dosage: 5 g/d</td>
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<td>Fructose and lactose</td>
<td>Children aged 3–14 y (N = 21)</td>
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<td>Dosage: 2 dd 200 mL</td>
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<td>van Tilburg et al (2009); United States</td>
<td>Children aged 6–15 y (N = 34) FAP (abdominal pain at least once a week in the past 3 mo)</td>
<td>Standard care + guided imagery; 3 biweekly sessions, including 1 booster session + 3 daily sessions. Listen to CD with self exercises ≥5 d/wk Control: standard care Treatment period: 2 mo Follow-up: 6 mo</td>
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<td>Low</td>
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<td>Children aged 8–18 y (N = 53) FAP and IBS (Rome II criteria)</td>
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<td>Sanders et al (1994); Australia</td>
<td>Children aged 7–14 y (N = 44) RAP (Apley’s criteria)</td>
<td>6-session CBT-family Control: standard care Treatment period: 8 wk Follow-up: 6 and 12 mo</td>
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<td>Robins et al (2005); United States</td>
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<td>Psychological + psychotherapy Control: physiotherapy Treatment period: at least 2 sessions, according to the expressed needs Follow-up: 12 mo</td>
<td>Abdominal pain intensity Instrument: VAS Pain score at 1-year follow-up Instrument: VAS + duration (min) + frequency (per week)</td>
<td>Very low</td>
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<td>Humphreys and Gewirtz (2000); United States</td>
<td>Children aged 4–18 y (N = 84) RAP</td>
<td>4 groups: 1. Fiber + biofeedback + CBT + parental support 2. Fiber + biofeedback + CBT 3. Fiber + biofeedback 4. Food Treatment period: 8-session CBT Dosage: 10+ g/d fiber cookies or bars Follow-up: no follow-up</td>
<td>Abdominal pain intensity Instrument: VAS School absenteeism Instrument: Record of school attendance</td>
<td>Moderate</td>
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</tbody>
</table>
(aged 7–17 years) receiving 4 weeks of glucomannan or identical placebo. Pain severity was assessed by using the Faces Pain Scale–Revised (6 faces ranging from relaxed to intense pain). School absenteeism and changes in daily activities were self-reported. The primary outcome in all studies was degree of improvement based on abdominal pain frequency or intensity. After pooling, there was no significant difference between the fiber group in experiencing “no pain” and/or “satisfactory improvement” (52.4%) and the placebo group (43.5%) (RR: 1.17 [95% CI: 0.75 to 1.81]). Concerning secondary outcomes, no significant differences for school absenteeism (10% vs 14%; \( P = .56 \)) or daily activities (27% vs 19%; \( P = .37 \)) after glucomannan treatment compared with placebo were found.38

### TABLE 1 Continued

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<th>Outcome Measures and Instruments</th>
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<td>Groβ and Warschburger28 (2013); Germany</td>
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<td>6-session CBT (group sessions) + listen to CD with self exercises. Control: wait-list. Treatment period: 2 mo. Follow-up: 3 mo.</td>
<td>Abdominal pain intensity. Instrument: VAS.</td>
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<td>Probiotics</td>
<td>Bausserrman and Michail41 (2005); United States</td>
<td>Children aged 6–17 y (N = 64); IBS (Rome II criteria)</td>
<td>LGG versus placebo. Dosage: 10^10 CFU, twice daily. Treatment period: 8 wk. Follow-up: no follow-up.</td>
<td>Abdominal pain intensity. Improvement: no pain or a change in the FPS-R by at least 2 faces. Instrument: VAS.</td>
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<td>Francavilla et al43 (2010); Italy</td>
<td>Children aged 5–14 y (N = 141); IBS and FAP (Rome II criteria)</td>
<td>LGG vs placebo. Dosage: 3 \times 10^9 CFU, twice daily. Treatment period: 8 wk. Follow-up: 8 wk.</td>
<td>Abdominal pain (frequency/severity). Treatment success: a decrease of at least 50% in the number of episodes and intensity of pain. Instrument: VAS.</td>
<td>Moderate</td>
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<tr>
<td>Gawrońska et al42 (2007); Poland</td>
<td>Children aged 6–16 y (N = 104); FAP, functional dyspepsia, and IBS (Rome II criteria)</td>
<td>LGG versus placebo. Dosage: 3 \times 10^9 CFU, twice daily. Treatment period: 4 wk. Follow-up: no follow-up.</td>
<td>Abdominal pain intensity. Improvement: no pain or a change in the FPS-R by at least 2 faces. Instrument: PedsQL.</td>
<td>Moderate</td>
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<td>Guandalini et al27 (2010); Italy and India</td>
<td>Children aged 4–18 y (N = 59); IBS (Rome II criteria)</td>
<td>VSL#3 vs placebo. Dosage: 4–11 y, 1 sachet; 12–18 y, 2 sachets. Treatment period: 6 wk. Follow-up: no follow-up.</td>
<td>Abdominal pain score (frequency and intensity). Responders: decreased pain score of ≥1 point. Instrument: self-administered questionnaire.</td>
<td>Very low</td>
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CAP, chronic abdominal pain; FD, functional dyspepsia; FPS-R, Faces Pain Scale–Revised; GNN, glucomannan; IBS-C, irritable bowel syndrome, constipation predominant; IBS-D, irritable bowel syndrome, diarrhea predominant; NA, not applicable; PedsQL, Pediatric Quality of Life Inventory.
Romano et al.\textsuperscript{24} enrolled 60 patients (aged 8–16 years) and compared 4 weeks of partially hydrolyzed guar gum (PHGG), a water-soluble, dietary fiber, with placebo. Symptoms were assessed by using the Birmingham IBS Symptom Questionnaire, which contains questions on frequency of IBS symptoms (0 = none, 5 = all the time),\textsuperscript{52} and the Wong-Baker FACES Pain Rating Scale, which was used to evaluate abdominal pain severity (0 = no hurt, 5 = hurts worst).\textsuperscript{53} The primary outcome was reduction in the frequency and intensity of IBS symptoms. Improvement in the frequency of IBS symptoms was significantly more likely in the PHGG group compared with the control group (43\% vs 5\%; \(P = .025\)) after 8 weeks. Effects on pain intensity were not significant.

Three studies assessed adverse effects.\textsuperscript{24,37,38} Unknown small numbers of children in both groups reported gas or diarrhea in the trial by Feldman et al.\textsuperscript{37} Horvath et al.\textsuperscript{38} and Romano et al.\textsuperscript{24} reported no adverse effects.

### Lactose-Free Diet

Huertas-Ceballos et al.\textsuperscript{15} included 2 trials evaluating a lactose-free diet in RAP.\textsuperscript{39,40} Lebenthal et al.\textsuperscript{49} enrolled 95 participants. After an intestinal biopsy was conducted, those patients with abnormal lactase activity (12–20 U) were excluded: 69 children received 6 weeks of lactose-containing or lactose-free infant formula. Abdominal pain was documented in diaries by parents. Remarkably, 31 children were excluded due to a lack of compliance; 38 children remained. A lactose tolerance test was performed, the results of which were used to divide children into 2 groups: lactose malabsorbers (\(n = 21\)) and lactose absorbers (\(n = 17\)). Increased symptoms were described in 48\% of the lactose malabsorbers and 24\% of the lactose absorbers after lactose intake; however, \(P\) values were not reported. Forty of the 69 children continued with a 12-month lactose-free diet. Improvement of abdominal pain after 12 months was similar in both groups (40\% vs 38\%). Detailed data were not reported, however, and meta-analysis and GRADE evidence profiling were therefore not possible. Dearlove et al.\textsuperscript{49} included 21 children with RAP in a double-blind, single crossover study. After 2 weeks of collecting baseline data, all children underwent a 2-week lactose-free diet, followed by another 2 weeks of lactose tonic (2 g/kg) or similarly flavored placebo. Primary and secondary outcomes were not specified. After 3 months, parents were asked whether their child’s symptoms (including abdominal pain) were better, worse, or the same. There was no difference in the number of children claiming relief from the lactose-free or lactose-containing formula.

### Hypnotherapy

One systematic review\textsuperscript{11} (including 2 RCTs\textsuperscript{32,44}) and 1 RCT\textsuperscript{25} evaluated the effects of HT for FAP and IBS. Two studies examined HT by therapists\textsuperscript{25,32} and 1 examined HT with self exercises on a CD.\textsuperscript{44} All studies used diaries to assess pain intensity and frequency. Gulewitsch et al.\textsuperscript{25} recalculated pain scores into an abdominal pain index. The abdominal pain index, disability, and school absenteeism were the primary outcomes. Clinical remission was defined as a \textgreater{}80\% decrease on the abdominal pain index: 55\% (11 of 20) of children showed clinical remission after HT, compared with 5.6\% (1 of 18) of wait-list control subjects (RR: 9.90 [95\% CI: 1.14 to 69.28]).

Vlieger et al.\textsuperscript{30,32} included 53 children in their research. Clinical remission, defined as a \textgreater{}80\% reduction in abdominal pain scores, was the primary outcome. After 3 months of HT, 59\% showed clinical remission compared with 12\% receiving standard care (\(P < .001\)). Differences persisted after 1 year (85\% vs 25\%; \(P < .001\)) and after 5 years (68\% vs 20\%; \(P = .005\)).

Van Tilburg et al.\textsuperscript{44} compared 19 children receiving 2 months of standard care plus HT through self exercises on a CD with 15 children receiving standard care. Primary or secondary outcomes were not specified. Efficacy was based on an abdominal pain index,\textsuperscript{54} with higher scores indicating more abdominal pain (range: 0–40). At treatment, children receiving HT reached an improvement of 9.7 points compared with 3.1 points in the control subjects (\(P = .02\)). Significantly more children responded to HT compared with control subjects (63\% vs 27\%; \(P = .03\)). At 6 months’ follow-up, beneficial effects persisted in 62.5\% of the HT group.

Two trials assessed quality of life, but the results were conflicting.\textsuperscript{25,44} To evaluate this secondary outcome, Gulewitsch et al.\textsuperscript{25} used the validated German KINDL questionnaire. No significant effects were reported by children (\(P = .120\)) or parents (\(P = .678\)) compared with control subjects. Van Tilburg et al.\textsuperscript{44} demonstrated a significant quality of life improvement compared with standard care (\(P = .049\)), measured by using the validated Pediatric Quality of Life Inventory. Two studies reported significant improvement in disability.\textsuperscript{25,44} Gulewitsch et al. used the Pediatric Pain Disability Index to assess impairment in 12 daily activities. HT had a significant beneficial effect on the self-reported disability compared with control subjects (MD: –9.14 [95\% CI: –14.41 to –3.87]).\textsuperscript{25} Van Tilburg et al. used the Functional Disability Inventory. Children receiving HT exhibited a significant reduction in disability compared with control subjects (\(P = .01\)).

Two studies did not describe differences in school absenteeism between either treatment group.\textsuperscript{32,44} In 1 trial, school absenteeism was seldom reported, and therefore no
calculation was performed. One child dropped out because of transient headaches after listening to the CD. Gulewitsch et al reported no adverse effects.

**Cognitive Behavioral Therapy**

Two systematic reviews (including 6 RCTs) and 1 RCT were included in the assessment of the various CBT methods. Four trials evaluated the efficacy of family-focused CBT (ie, CBT-family). A visual analog scale (VAS) and the Faces Pain Scale—Revised were used to assess pain intensity. Robins et al used the abdominal pain index for assessments. Only Levy et al specified primary outcomes, which were abdominal pain intensity and disability scores. A significantly higher proportion of children in the trial by Sanders et al were pain free after CBT-family compared with standard care (MD: -3.61 [95% CI: -5.76 to -1.46]). These changes persisted at 6 months (P = .02) but had disappeared at the 12-month follow-up. Duarte et al reported significantly decreased abdominal pain frequency at 3 months’ follow-up (P = .001), but no effect was seen for pain intensity. In the study by Robins et al, CBT-family added to standard care resulted in a significantly lower abdominal pain index compared with standard care alone (P < .05), with continuing effects at 6 and 12 months of follow-up. Levy et al compared CBT-family with education and support intervention in 200 children. A significant reduction in pain intensity as indicated by parents was reported after 3 sessions of CBT-family (P < .01). This reduction persisted for 12 months but was not significant when reported by children. There was no beneficial effect of CBT-family for disability, but a significant improvement in school absenteeism was reported after CBT-family plus standard care (P = .047).

Two studies evaluated the effects of individual CBT. Alfén and Lindstrom randomized children to undergo CBT plus physiotherapy (n = 25) or physiotherapy alone (n = 23). Pain intensity score (1–3), frequency score (1–3), and duration score (1–3) were summed into individual pain scores ranging from 3 to 9. Pain score reduction at the 1-year follow-up was not significantly different between groups (46% vs 44%; P value not reported). Humphreys and Gervitz divided 64 patients (aged 4–18 years) into 4 groups to compare CBT, fiber supplements, biofeedback, and parental support in different combinations. Children kept diaries and reported pain intensity by using a VAS; the primary outcome was the number of self-reported pain-free days. Results of the first 3 groups (CBT, biofeedback, and parental support) were combined and compared with a group receiving fiber supplements. After treatment, 33 (72%) of 46 children in the intervention groups were pain free compared with 1 (7.1%) of 14 children taking fiber supplements only (OR: 33.0 [95% CI: 3.9 to 278.5]). Humphreys and Gervitz investigated school absenteeism and reported significant effects favoring CBT.

Groß and Warschburger compared children in the CBT group sessions (n = 15) versus wait-list control subjects (n = 14). Pain intensity was assessed by using a VAS. Although primary outcomes on pain intensity (P = .001), frequency (P = .003), and duration (P = .002) significantly improved after CBT, only pain duration was still significant at 3 months’ follow-up (P = .014). Quality of life was measured as a secondary outcome by using the Pediatric Quality of Life Inventory. A significant improvement favoring CBT was reported on physical functioning (P < .001), psychological functioning (P = .003), social functioning (P = .044), and school functioning (P = .012). However, results disappeared after 3 months of follow-up.

**Written Self-Disclosure**

Wallander et al evaluated WSD in addition to standard care in 63 children (aged 11–18 years) with RAP. In three 20-minute sessions, patients were asked to write about their “deepest thoughts and feelings about the most distressing experience in their life.” Primary and secondary outcomes were not specified. Seven patients were lost to follow-up and were excluded from analyses. Abdominal pain frequency was rated by using a 6-point scale. Although there were no differences at 3 months, pain frequency was significantly less after WSD and standard care at the 6-month follow-up compared with standard care alone (F [1,51] = 6.50, P = .014, Cohen’s d = 0.61). Physical and psychosocial quality of life was measured by using the Pediatric Quality of Life Inventory, and no significant differences were reported.

**Prebiotics or Probiotics**

One systematic review (including 3 RCTs) evaluated the effects of *Lactobacillus rhamnosus* GG compared with placebo. Data were pooled by Horvath et al for treatment responders and treatment success, which were secondary outcomes. Baussner and Michail classified children as responders if abdominal pain severity decreased ≥1 point on a 4-point Likert scale. Francavilla et al used a VAS and defined treatment success as a decrease of >50% of pain episodes and intensity. Gawrońska et al defined treatment success as no pain or change in the Faces Pain Scale—Revised by ≥2 faces. LGG supplementation was associated with significantly more treatment responders (67%) compared with placebo (51%) (n = 290; RR: 1.31 [95% CI: 1.08 to 1.59]; number needed to treat: 7 [95% CI: 4 to 22]). Subgroup analysis showed results being mainly applicable for IBS (n = 167; RR: 1.70 [95% CI: 1.27 to 2.27]; number needed to treat: 4 [95% CI: 3 to 8]). Guandalini et al
conducted a crossover trial, comparing 6 weeks of VSL#3 versus placebo in 59 children with IBS. VSL#3 is a probiotic mixture comprising 8 different strains of *Bifidobacterium, Lactobacillus*, and *Streptococcus*. After a 2-week washout period, each patient switched to the other group for another 6 weeks of treatment. Abdominal pain was measured as a secondary outcome: frequency and intensity were rated on a 5-point Likert scale. After treatment, a significant reduction in the abdominal pain score of $1.0 \pm 0.2$ was reported in the VSL#3 group versus $0.5 \pm 0.2$ in control subjects ($P < .05$). One study evaluated school absenteeism, but no significant difference was found. No adverse effects of LGG were reported, although it was unclear in 2 studies how adverse effects were assessed.

No studies were included on prebiotics.

**Alternative Medicine**

One study of the systematic review by Birdee et al was included regarding alternative therapy. Kuttn er et al compared 14 children receiving yoga versus 11 wait-list control subjects. After 4 weeks, questionnaires were completed, and control subjects received 4 weeks of yoga and completed additional questionnaires. Pain intensity was measured on a numeric scale of 0 to 10. Results before the crossover phase were not reported because of baseline differences. Functional disability decreased after yoga but increased in control subjects (MD: $-9.60$ [95% CI: $-19.66$ to $0.46$]). Primary or secondary outcomes were not specified.

No studies were included evaluating acupuncture, homeopathy, mind–body therapy, or musculoskeletal manipulations such as osteopathic and chiropractic manipulations.

**DISCUSSION**

This systematic review includes 24 studies that were of very low to moderate methodologic quality. Some evidence was found indicating beneficial effects of PHGG, HT, CBT, and probiotics (LGG and VSL#3). No beneficial effects were reported for fiber supplementation other than PHGG and a lactose-restricted diet. No studies were included on lifestyle advice, other dietary advice, or prebiotics. No serious adverse effects were reported.

Dietary interventions are frequently used in AP-FGIDs because many patients and some physicians consider symptoms to be meal related. Fiber supplementation is believed to be helpful because it softens stools and enhances colonic transit. However, studies in children and adolescents evaluating ispaghula husk and glucomannan found no favorable effects. Improvement in abdominal pain frequency was reported after administration of corn fiber, but questions were raised whether the statistical analyses were adequate. Re-analyses by Huertas-Ceballos et al. failed to replicate the findings. Adult studies produced conflicting results and a meta-analysis reported only beneficial effects for ispaghula husk. The main component of PHGG is galactomannan, which softens stool, improves fecal output, and increases bulk capacities. PHGG treatment in IBS children found a reduced frequency in IBS symptoms, but pain intensity was not decreased.

Results of an open-label PHGG trial in adult patients with IBS produced significant improvements in gastrointestinal symptoms, quality of life, and psychological distress, but the effects tended to diminish after the 12-week treatment period.

Malabsorption and intolerance to carbohydrates such as fructose and lactose are believed to cause symptoms such as bloating, diarrhea, and abdominal pain. However, neither lactose nor fructose intolerance was established as a cause of pain in 220 children with RAP in a recent study, and lactose restriction did not improve symptoms in pediatric trials. Recently, diets of low fermentable oligosaccharides, disaccharides, monosaccharides, and polyols (FODMAP) have been extensively studied in adults. FODMAPS are poorly absorbed short-chain carbohydrates, which may cause gas production, bloating, and abdominal pain. A low FODMAP diet seemed beneficial in adult IBS trials, but due to heterogeneity in study design and outcomes and because of unknown long-term safety and efficacy, definitive conclusions cannot be drawn. Recently, a randomized, double-blind, crossover trial in 33 children with IBS reported improvement in abdominal pain after receiving a 48-hour low FODMAP diet. Although these results seem promising, more long-term studies are needed to further assess the efficacy and safety of a low FODMAP diet in children and adolescents.

In HT, suggestions toward control and normalization of gut functioning, ego strengthening, and stress reduction are conveyed to patients after inducing a hypnotic state. Results of studies in children and adolescents found significantly lower abdominal pain levels and symptom scores after HT, either through individual or group sessions with therapists or with self exercises on a CD. Effects persist up to 5 years after treatment. Results are in accordance with adult IBS trials showing that HT is superior to a variety of control treatments, with long-lasting effects. Working mechanisms of HT are still poorly understood, but outcomes of adult studies hypothesize that HT affects both physiologic processes, such as colonic motility and pain-processing brain regions, and psychological factors, such as stress and dysfunctional cognitions.
CBT aims to change attitudes, cognitions, and behavior that may play a role in generating or maintaining symptoms and is effective in improving pain and other IBS symptoms in adults. Trials in children and adolescents also indicate beneficial effects of CBT, especially CBT-family, in improving pain and disability, and the effects seem to be long-lasting. Results of the trial by Levy et al are of particular interest because it included 200 children and adolescents. An RCT on individual CBT published shortly after the literature search showed improvement in 60% of children with FAP after CBT, but the results did not differ compared with standard care (including 6 supportive sessions with the pediatric gastroenterologist). However, children receiving CBT reported significantly fewer symptoms of anxiety or depression compared with children receiving standard care.

WSD targets psychosocial stress and may work through changing expression and increasing insight about emotions. It is reportedly effective in a wide variety of adult organic and functional disorders. WSD in addition to standard care significantly reduced pain frequency after 6 months in pediatric RAP but not after 3 months. Although further research is needed, WSD may be a useful adjunct to other treatment regimens because it can be easily integrated, requires little training, and has low costs. Probiotics are beneficial species of bacteria that may improve AP-FGIDs symptoms by preventing overgrowth of potentially pathogenic bacteria, maintaining integrity of gut mucosa, and/or altering intestinal inflammatory responses. RCTs in children and adolescents evaluating LGG and VSL#3 in FAP, IBS, and functional dyspepsia indicate beneficial effects over placebo, but probiotics seem mostly effective in IBS. Probiotics also seem effective in adults with AP-FGIDs, but future research must clarify which probiotic strains are most effective. Although >40% of children with IBS and FAP use complementary and alternative medicine, data are lacking on the efficacy and safety of almost all forms of this treatment in children and adolescents. Yoga may address psychosocial factors and decrease stress. Kuttner et al reported significantly lower levels of functional disability and gastrointestinal symptoms after yoga, but it is noteworthy that P values <.1 were considered reflective of statistical trends worthy of interpretation. However, a pilot study in children and adolescents aged 8 to 18 years with IBS and FAP also found significant short-term improvement in abdominal pain frequency and intensity. It thus seems worthwhile to further explore the efficacy of yoga. Because treatment protocols in CBT, HT, and yoga all incorporate relaxation exercises, one might hypothesize that relaxation training alone can also be beneficial in AP-FGIDs. This therapeutic approach may be interesting to address in future research because it has been shown to be effective in children and adolescents with recurrent headaches as well.

The methodologic quality of the included studies varied from very low to moderate, and the results should therefore be interpreted cautiously. The low quality was mainly due to small sample sizes, lack of adequate follow-up, substantial dropout rates, or considerable risk of bias. However, it should be taken into account that blinding of patients and caregivers is not possible in psychological therapies such as HT or CBT. By using validated diagnostic criteria for AP-FGIDs, applicability of results is increased, which strengthens the results. Due to considerable heterogeneity of studies, meta-analysis could only be conducted for fiber supplementation and probiotics. Other possible limitations of this systematic review include the possibility of publication bias and language restriction to English. However, by conducting a comprehensive and contemporaneous literature search, we attempted to minimize the risk of missing relevant studies. Use of a wide variety of definitions for clinical improvement also hampers the interpretation of results. Clinical relevance of a 1-point reduction on a 4-point Likert scale may be questioned, whereas an 80% reduction in abdominal pain frequency and intensity scores seems overly conservative.

Unfortunately, a standard definition of improvement for therapeutic studies on AP-FGIDs is lacking. Consensus on a standard definition is necessary because it increases the homogeneity of future trials and allows better comparison of results. In addition, performing analyses on number needed to treat and RR is often restricted because most RCTs fail to report on numbers or percentages of patients experiencing significant improvement.

A limited number of RCTs (n = 8) reported on adverse effects, thereby hindering interpretation of results on safety. However, in those studies, no serious adverse effects were shown, apart from a small number of children reporting gas or diarrhea. In interpreting FGID trials, the placebo effect may play an important role. Placebo responses in trials of adults with IBS vary from 16.0% to 71.4%, and high placebo rates up to 53% were reported in RCTs on children and adolescents. High placebo responses may also display natural course of FGIDs with fluctuating symptoms. Improving the patient-practitioner relationship and active listening approaches are essential in mediating placebo responses. This may be especially important in nonpharmacologic therapies in which
contact with therapists is mostly frequent.81,82

CONCLUSIONS

To date, high-quality studies on nonpharmacologic treatments in pediatric AP-FGIDs are lacking, and the need for these studies is evident. However, available evidence indicates beneficial effects of HT, CBT and probiotics (LGG and VSL#3) in some children. Data on fiber supplementation for children and adolescents with AP-FGIDs are inconclusive, but PHGG may be an option. No serious adverse effects were reported.

Because symptoms may resolve without active treatment in a significant proportion of children, the first step in management may consist of physician reassurance and education. However, approximately one-third of children continue to experience symptoms.83 Clinicians may consider HT, CBT, or probiotics (LGG and VSL#3), especially in children with persistent symptoms. Additional high-quality studies are required in children with mild as well as severe symptoms to further assess the effectiveness of nonpharmacologic therapies and to identify factors predicting response, with the goal of optimizing and tailoring individual treatments. Because abdominal pain is the key symptom in AP-FGIDs and to decrease heterogeneity, we emphasized the importance of including abdominal pain severity, frequency, and/or intensity as a primary outcome measure in trials evaluating nonpharmacologic treatments for AP-FGIDs. In addition, adverse effects need to be reported systematically to better assess safety.

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**WARMWATERBLUES:** When I was a teen, I would occasionally go cod fishing off the coast of Maine or Massachusetts with my father. While we did not catch particularly large numbers of fish, we always caught enough cod for several dinners. In those days, cod was a staple of New England fish restaurants. That has changed. The cod population off of the coast of New England has collapsed – so much so that, as reported in *The New York Times* (U.S.: December 15, 2014), cod fishing has been banned since November for six months as regulators decide how to address the problem.

While overfishing has certainly contributed, a problem that cannot easily be addressed by state and federal regulators is the warming of the Gulf of Maine waters. Historically, the water temperature in the Gulf of Maine had warmed on average about one degree every two decades or so. In the past decade, the water has warmed by about one degree every two years. This has led to changes in the ecosystem. Maine shrimp have fled for colder climates, leading regulators to cancel the Maine shrimp harvest for the second year in a row. Black sea bass, native to warmer southern waters and previously rarely seen off the coast of Maine, have become abundant. Blue crab, so closely linked to the Chesapeake, has made an appearance. Lobsters have become much more plentiful with record harvests for several years in a row, but the center of the lobster industry has moved at least 50 miles to the north. The toll on the economy and human life may be quite severe. Precluded from fishing for at least six months, Maine’s fishermen have few options to support themselves. This is just another example of how intertwined humans and animals are with the ecosystems and the complex interplay between each and all its parts.

*Noted by WVR, MD*
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