RECENT ADVANCES PEDIATRIC GASTROENTEROLGY: Supplement to vol26 EB-PGHN journal.

CONSTIPATION: Constipation is a symptom not the diagnosis. We need to diagnose underlying disorder.Based on colonic transit time, persistent constipation may be divided into three categories: 1) anorectal retention (outlet obstruction, dyssynergic defecation), 2) slow colonic transit and 3) normal transit. Approximately 70% of children with chronic treatment-resistant constipation have anorectal retention and 20% have slow colonic transit. Complete bowel evacuation is necessary as the first step in treating chronic constipation (CC) because if initial disimpaction is omitted, maintenance therapy with oral stool softeners and laxatives may initially result in worsening of incontinence.**There are no trails which proves the use of dietary fiber in constipation**. Induction therapy is important prior maintainance. liquid paraffin should not be used in children aged under 3 years in the UK **There is very little empirical data to support use of stimulant laxative.**

REFRENCE:
1.Constipation Guideline Committee of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition. Evaluation and treatment of constipation in infants and children: recommendations of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition. J Pediatr Gastroenterol Nutr 2006; 43: e1–e13.
2. Tabbers MM, Berger MY, Kurver M, et al. Accuracy of diagnostic testing for functional constipation in children: a systemic review. submitted.

INFANTILE COLIC: Lactobacillus reuteri ATCC 55730 improved colicky symptoms in breastfed infants within 1 week of treatment

REFRENCE:
Savino F, Pelle E, Palumeri E, et al. Lactobacillus reuteri (American Type Culture Collection Strain 55730) versus simethicone in the treatment of infantile colic: a prospective randomized study. Pediatrics 2007;119:e124–30.

FUNCTIONAL DIORDERS: No studies have been published on the efficacy of antispasmodics in children. A Cochrane's review of pediatric studies concluded that for **the majority of antidepressant medications no evidence exists to support their use**. Fecal calprotectin seems to be a reliable marker in distinguishing patients with possible inflammatory processes from those with FGID. Cognitive behavioral therapy and hypnotherapy as the best studied and probably most effective types of treatment for chronic nonspecific abdominal pain.

REFRENCE:
1.Kaminski A, Kamper A, Thaler K, et al. Antidepressants for the treatment of abdominal pain-related functional gastrointestinal disorders in children and adolescents. Cochrane Database Syst Rev 2011;7:CD008013
2. Chiou E. Management of functional abdominal pain and irritablebowel syndrome in children and adolescents. Expert Rev Gastroenterol Hepatol 2010;4:293–304.

GERD:

Upper endoscopy with multiple biopsies is the most superior method to detect esophagitis as a consequence of GERD. Barium contrast, scintigraphy, **Ultrasound are not recommended for the diagnosis of GERD**.**No role of empirical PPI therapy in infants. 4 weeks of empirical PPI therapy > 1year may be useful**. Thickening feeds should at least be tried in the treatment of healthy infants with GER, but also in infants with GERD.

REFRENCE:
Vandenplas Y, Rudolph CD, Di Lorenzo C, et al. Pediatric gastroesophageal reflux clinical practice guidelines: joint recommendations of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN) and the European Society for Pediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN). J Pediatr Gastroenterol Nutr 2009;49:498–547.

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