Appendix D

Clinical Diagnostic Questionnaire for Pediatric Functional Gastrointestinal Disorders

The purpose of the Pediatric Diagnostic Questionnaire* is to provide physicians with a clinical aid to diagnose pediatric functional gastrointestinal disorders during the patient interview. The diagnostic criteria are presented in the form of questions grouped by disorder. There is a check box for either yes or no before the diagnostic item. Items indicated in italics require additional clinical information (e.g., results of diagnostic procedures, response to treatment, etc.).

Scoring requires that each item be addressed and when indicated marked in the appropriate box. When all items within a diagnostic category are checked, the patient meets criteria for the functional GI disorder.

The following criteria apply only if (1) symptoms are chronic or recurrent for at least the amount of time indicated, and (2) based on adequate medical evaluation the symptoms are not attributable to other gastrointestinal disease.

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Rome II Pediatric Questionnaire

G1. Vomiting

G1A. Infant Regurgitation

1. ❑ Yes For at least 3 weeks, has your child regurgitated 2 or more times per day?

2. Has your child had any of the following symptoms:
   - ❑ No Retching
   - ❑ No Blood in the spit-up
   - ❑ No Aspiration
   - ❑ No Poor weight gain
   - ❑ No Apnea

3. How old is your child?
   - ❑ Yes 1 to 12 months of age
   - ❑ Yes Is your child otherwise healthy?
   - ❑ No *Is there evidence of metabolic, gastrointestinal, or central nervous system disease to explain the symptom?*

G1B. Infant Rumination Syndrome

1. ❑ Yes For at least 3 months, when not vomiting, did your child often bring up food, rechew it, and either spit it out or reswallow it?

2. ❑ Yes Did this start when your child was between 3 and 8 months of age?

3. ❑ No Does this occur during sleep?

4. ❑ No Does this occur when the infant is interacting with family or friends?

5. ❑ No Does your baby seem distressed by this?

6. ❑ No *Has the baby responded to management for gastroesophageal reflux disease, anticholinergic drugs, hand restraints, formula changes, and gavage or gastrostomy feedings?*

G1C. Cyclic Vomiting Syndrome

1. ❑ Yes Has your child had 3 or more periods of intense, acute nausea and vomiting lasting hours to days?
2. ❑ Yes Between episodes, does your child have symptoms-free intervals lasting weeks to months?
3. ❑ No *Is there metabolic, gastrointestinal or central nervous system structural or biochemical disease*?

2G. Abdominal Pain

G2A. Functional Dyspepsia

1. ❑ Yes Is the child mature enough to give an accurate pain history?
2. ❑ Yes For at least 12 weeks (*need not be consecutive)* in the past year, has your child had persistent or recurrent pain or discomfort centered in the upper abdomen (above the umbilicus)?
3. ❑ No Is the pain or discomfort relieved by defecation?
4. ❑ No Is the pain or discomfort associated with the onset of a change in stool frequency or stool form?
5. ❑ No *Is there clinical, biochemical, endoscopic, or ultrasonographic evidence that organic disease is likely to explain the symptoms?*

To distinguish type of dyspepsia, examine the answers in the following three categories: ulcer-like dyspepsia, dysmotility-like dyspepsia, and unspecified (non-specific) dyspepsia.

G2A1. Ulcer-like Dyspepsia

1. ❑ Yes Is the pain centered in the upper abdomen the predominant, most bothersome symptom?

G2A2. Dysmotility-like Dyspepsia

1. ❑ Yes Is the unpleasant or troublesome non-painful sensation (discomfort) centered in the upper abdomen the prominent symptom?

2. Is this sensation characterized by (*any of the following*)?
   - ❑ Yes Feeling full after eating very little
   - ❑ Yes Upper abdominal fullness
   - ❑ Yes Bloating
   - ❑ Yes Nausea.

G2A3. Unspecified (nonspecific) Dyspepsia

1. ❑ No *Does the patient fulfill criteria for either ulcer-like or dysmotility-like dyspepsia?*

G2B. Irritable Bowel Syndrome

1. ❑ Yes Is the child old enough to provide an accurate pain history?
2. ❑ Yes For at least 12 weeks (need not be consecutive) in the past year, has your child complained of abdominal discomfort or pain?
3. Is this discomfort or pain (*two out of three*):
   - ❑ Yes Relieved by a bowel movement
   - ❑ Yes Associated with a change in frequency of bowel movements
   - ❑ Yes Associated with a change in the form (appearance) of bowel movements
4. ❑ No *Are there structural or metabolic abnormalities to explain the symptoms?*
5. Is this discomfort or pain accompanied by: (*Symptoms that cumulatively support the diagnosis of IBS but are not necessary for diagnosis. Any of the following:*)
   - ❑ Yes Abnormal stool frequency (greater than 3 BMs per day or fewer than 3 BMs per week)?
   - ❑ Yes Abnormal stool form (lumpy/hard or loose/watery stool)?
   - ❑ Yes Abnormal stool passage (straining, urgency, or feeling of incomplete evacuation)?
   - ❑ Yes Passage of mucus?
   - ❑ Yes Bloating or feeling of abdominal distension?

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G2C. Functional Abdominal Pain Syndrome

1. ❑ Yes For at least three months has your school-aged child or adolescent had continuous or nearly continuous abdominal pain?
2. ❑ No or only occasionally Is the pain related to eating, menses, or defecation?
3. ❑ Yes Has this pain interfered with your child's daily activities (ability to go to school or social activities)?
4. ❑ No *Is the pain is feigned?*
5. ❑ No *Does the child meet criteria for other functional gastrointestinal disorders that would explain the abdominal pain?*

G2D. Abdominal Migraine

1. ❑ Yes For at least one year has your child complained of three or more episodes of intense, acute midline abdominal pain lasting from 2 hours to several days?
2. ❑ Yes Does your child have symptom-free intervals lasting weeks to months?
3. Does your child complain of any of the following (*at least two*):
   a. ❑ Yes Headache during episodes?
   b. ❑ Yes Photophobia during episodes?
   c. ❑ Yes Family history of migraine?
   d. ❑ Yes Headache confined to one side only
   e. ❑ Yes An aura or warning period consisting of either visual disturbances (e.g., blurred or restricted vision), sensory symptoms (numbness or tingling), or motor abnormalities (slurred speech, inability to speak, paralysis).
   f. ❑ No *Is there evidence of metabolic, gastrointestinal, or central nervous system structural or biochemical diseases?*

G2E. Aerophagia

For 12 weeks (*need not be consecutive*) or more in the past year has your child (*two of the following*):

1. ❑ Yes Swallowed air
2. ❑ Yes Had a bloated stomach
3. ❑ Yes Belched or passed gas repeatedly

G3. Functional Diarrhea (also called Toddler's Diarrhea, chronic non-specific diarrhea, irritable colon of childhood)

1. ❑ Yes For at least 4 weeks, has your child had 3 or more large, painless, unformed bowel movements each day?
2. ❑ Yes Did this symptom begin between 6 and 36 months of age?
3. ❑ Yes Does your child have bowel movements only when awake?
4. ❑ Yes Is your child growing and thriving?

G4. Disorders of Defecation

G4A. Infant Dyschezia

1. ❑ Yes Does your baby strain and cry at least 10 minutes before having a bowel movement with soft stool?
2. ❑ Yes *Is the infant less than 6 months of age*?
3. ❑ Yes *Is the infant otherwise healthy?*

G4B. Functional Constipation (*Either 1 or 2 and 3*)

1. ❑ Yes For at least 2 weeks has your child had pebble-like, hard stools most of the time? *or*
2. ❑ Yes For at least 2 weeks has your child had firm stools two or fewer times per week?
3. ❑ No *There is no evidence of structural, endocrine or metabolic disease.*

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G4C. Functional Fecal Retention

1. ❑ Yes For at least the past 3 months, has your child or adolescent passed large diameter stools less than 2 times per week?
2. ❑ Yes Does your child try to avoid having a bowel movement by squeezing the legs or buttocks together?
3. *Accompanying symptoms may include the following and disappear immediately following passage of a large stool.*
   - ❑ Yes Fecal soiling
   - ❑ Yes Irritability
   - ❑ Yes Abdominal cramps
   - ❑ Yes Decreased appetite
   - ❑ Yes Early satiety

G4D. Functional Non-Retentive Fecal Soiling

1. ❑ Yes For a week or more for the last 12 weeks, has your child had a bowel movement into places and at times inappropriate to the social situation?
2. ❑ Yes *Is the child older than four years?*
3. ❑ No *Is there evidence of structural or inflammatory disease?*
4. ❑ Yes *Are signs of fecal retention absent?*