



# PRACTICE

## CLINICAL UPDATES

# Abdominal migraine

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### What you need to know

- Abdominal migraine is episodic central abdominal pain occurring with other features of migraine and associated with other episodic syndromes (particularly cyclical vomiting and migraine limb pain)
- Abdominal migraine usually starts in childhood, though it may occur in adults, commonly with a family history of migraine
- The person is well between episodes with a normal physical examination and developmental milestones
- Abdominal migraine is a positive clinical diagnosis and requires no further investigation once "red flags" are excluded
- To manage abdominal migraine, provide an explanation of the diagnosis and discuss available acute and preventive treatments with the patient and family

### Sources and selection criteria

We performed a Medline search and search of Cochrane Collaboration and Clinical Evidence databases, using the terms "abdominal migraine," "episodic (periodic) syndromes," "childhood migraine," "recurrent abdominal pain," "functional abdominal pain." We gathered evidence on the treatment of childhood migraine and childhood pain from the Cochrane Collaborations, particularly with regard to safety of acute treatment of migraine in children. Guidelines of the Rome Foundation, International Headache Society and North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition informed discussion of definitions and management. These sources were supplemented by our personal archive of references, cited references from these, and discussions with other experts.

Abdominal migraine is an important, common, and under-recognised cause of recurrent abdominal pain in children. It may be associated with, or followed by, other forms of migraine, and it predicts adult migraine.<sup>1-4</sup> A positive diagnosis of abdominal migraine allows appropriate management and avoids unnecessary investigations and incorrect treatments.<sup>3,5</sup> Although the evidence base is limited, acute and preventive treatments are available. This article highlights the diagnosis and management of abdominal migraine for non-specialists.

## What is abdominal migraine?

Abdominal migraine is a functional disorder in the broad sense (a disorder without recognised structural or biochemical diagnostic abnormality<sup>6</sup>). It is an episodic syndrome on the migraine spectrum<sup>1 7</sup> and consists of intermittent central abdominal pain severe enough to interfere with normal activities.<sup>2-8</sup> The pain comes with migrainous features including sensory disturbance (photophobia, phonophobia), anorexia, nausea, vomiting, and pallor.<sup>7,8</sup> Crucially, the patient is symptom-free and well between episodes, with a normal physical examination, stable body mass index, and expected developmental milestones. These elements are agreed by consensus diagnostic criteria for abdominal migraine (the International Classification of Headache Disorders (ICHD-3beta)<sup>7</sup> and the Rome IV Classification of Gastroenterology Disorders<sup>9</sup>) and by earlier descriptions.<sup>8 10</sup>

Other aspects of the diagnosis are debated.<sup>4-12</sup> Headache as an accompanying feature is omitted by one classification,<sup>7</sup> excluding up to 70% of cases.<sup>3-13</sup> The consensus classifications require an arbitrary number of episodes, and at least two

migrainous features.<sup>7,9</sup> The stipulated duration of one<sup>9</sup> or two<sup>7</sup> hours misses briefer episodes,<sup>4</sup> as found in a hospital study in India<sup>5</sup> and in accord with the authors' experience. It is worth being aware of a possible diagnosis of abdominal migraine in those with some but not all consensus criteria.<sup>5-15</sup> Patients often have other episodic syndromes, excluded from both consensus criteria.<sup>1</sup> Boxed Text on page 2 Box 1 provides a practical definition based on current consensus diagnostic criteria, published evidence, and the authors' experience.

**Box 1 Recommended pragmatic clinical definition of abdominal migraine\***

- Episodic central abdominal pain, usually lasting >1 hour
- Episodes interfere with normal activity
- Episodes occur with one or more of pallor, anorexia, nausea, vomiting, photophobia, headache, or are associated with other episodic syndromes (particularly cyclical vomiting and migraine limb pain)
- Person is well between episodes
- Normal physical and developmental examination

\* Adapted from definitions of Symon and Russell,<sup>8</sup> ICHD-3beta,<sup>7</sup> and Rome IV<sup>9</sup> and published studies<sup>2-15</sup>

## How common is abdominal migraine?

Prevalence depends on definition, awareness, and setting in the absence of an objective diagnostic marker. In two British studies of children, population prevalence of abdominal migraine was 4.1% and 2.4% using the 1986 definition.<sup>2,13</sup> Using the Rome III diagnostic criteria,<sup>16</sup> prevalence was 9.2% in a US questionnaire study of the mothers of 949 children.<sup>17</sup> Population prevalence in a study of British schoolchildren peaked at 6-12 years, highest at 9% at 12 years, and falling to 1% at 14 years,<sup>2</sup> with a female:male ratio of 1.6:1.<sup>2</sup>

## What triggers and relieves abdominal migraine?

Stress, tiredness, travel, missed meals, and change in routine may trigger abdominal migraine,<sup>2,3</sup> as for all migraine. Sometimes, triggers may be confused with premonitory symptoms (symptoms preceding or forewarning of a migraine episode).<sup>7</sup> For example, bright light or low mood may seem to trigger an episode, when, in fact, photophobia and mood change are recognised premonitory symptoms.<sup>18</sup> Relieving factors for abdominal migraine, as for other migraines, are rest (in 88% of patients), sleep (in 64%), and analgesia (in 38%).<sup>2</sup>

## How do I diagnose abdominal migraine?

Typically a child with abdominal migraine presents to general practice or an emergency department with the features outlined in Boxed Text on page 2 box 1. The challenge is to distinguish it from organic and other functional causes of recurrent abdominal pain by confirming positive features and excluding "red flags" (⚠). "Red flags" suggest organic causes of abdominal pain (⚠), and so refer these children for an immediate expert opinion.<sup>22</sup> Assessment is particularly difficult in children less than 2 years old, who may not be able to explain or point to the pain. In them, abdominal pain often manifests with non-specific features such as inconsolable crying and pulling up of the legs. Patients with abdominal migraine often have a personal or family history of other types of migraine, similar undiagnosed episodes, or other episodic syndromes.<sup>3,4</sup>

Examination—including vital signs, temperature, and urine analysis—is normal apart from vasomotor changes (pallor, dark rings under the eyes).<sup>3,4</sup> Urine analysis is an important part of the physical examination, as patients with diabetic ketoacidosis or urinary tract infection may present with abdominal pain. If a child with previously diagnosed abdominal migraine presents again it may suggest that the child or carer is concerned there is something different about the episode. In this situation fully re-assess, especially if there are new or atypical symptoms or signs, as they could have a second acute diagnosis.

Other than abdominal migraine, neurological causes of abdominal pain are rare. In abdominal epilepsy, the pain is usually brief (seconds to minutes) and associated with altered awareness, and sometimes followed by a tonic-clonic seizure.<sup>23</sup>

Consensus guidelines suggest that children with a firm clinical diagnosis of abdominal migraine require no further investigations.<sup>9-24</sup>

## What causes abdominal migraine?

Specific changes to the gut-brain axis, vascular dysregulation, changes in the central nervous system, and genetic factors have been suggested as the cause of abdominal migraine.<sup>25</sup> It is not known why some people are vulnerable to this interaction between the central nervous system and the richly innervated gut, and whether this links with the trigemino-vascular system, which plays a major role in migraine headache.<sup>26,27</sup> No studies suggest vasospasm of small gut vessels as the cause of the periumbilical pain, but regional or central changes<sup>28,29</sup> in blood flow may be important, as they are for other forms of migraine.<sup>26</sup> The strong familial incidence in abdominal and other migraine suggests an important genetic role,<sup>30</sup> particularly for mutations involving cell membrane transport (channelopathies).<sup>31,32</sup>

## What other conditions is abdominal migraine associated with?

From population studies, 70% of those with abdominal migraine have current or previous migraine headache with or without aura.<sup>10</sup> Patients with abdominal migraine often have other concurrent or previous episodic syndromes (60% of 84 patients<sup>3</sup> and 30.6% of 1134 patients<sup>1</sup> in hospital series), particularly cyclical vomiting (66-76%)<sup>3-36</sup> and migraine limb pain.<sup>1-38</sup> Other possible associations are benign paroxysmal vertigo,<sup>39,40</sup> benign paroxysmal torticollis,<sup>1,31</sup> infantile colic,<sup>41,42</sup> Raynaud's disease,<sup>43,44</sup> and hypermobility<sup>45,46</sup> (see ⚠).

## Is abdominal migraine linked to mental health?

Avoid assuming that abdominal pain in children without demonstrable pathology has a psychogenic basis.<sup>3-47</sup> Links with anxiety,<sup>48,49</sup> depression,<sup>48-50</sup> psychosocial difficulties,<sup>49,51</sup> and abuse<sup>52</sup> are postulated. Some studies<sup>49-54</sup> and expert opinion<sup>12-57</sup> equate association and causality. Some studies are in uncontrolled<sup>52</sup> or unrepresentative populations,<sup>52</sup> have only pain-free controls,<sup>50</sup> group all functional abdominal pain as a homogenous diagnosis,<sup>49-58</sup> or underestimate population variability of paediatric anxiety and depression (3.8-11% depending on definitions, age, severity, and setting<sup>59</sup>). Controlled studies show that pain is associated with psychological distress, in children, adults, and families whatever the cause<sup>60,61</sup> or site.<sup>62</sup> Levels of depression and emotional adjustment were similar in children with functional abdominal pain and pain-free controls with minor illnesses.<sup>63</sup> Mood change as a premonitory symptom

or postdrome is recognised in outpatient studies of paediatric migraine,<sup>64,65</sup> but there are no specific data on prevalence in abdominal migraine.

## What happens to children with abdominal migraine as they grow up?

Children with abdominal migraine or other episodic syndromes usually have an excellent prognosis with no neurological or developmental deficits.<sup>10</sup> A longitudinal study in 54 schoolchildren showed the clinical diagnosis of abdominal migraine was robust (using adapted criteria of Symon and Russell<sup>8</sup>). It resolved in 61% at 8-10 year follow-up.<sup>10</sup> The prevalence and outcome of abdominal migraine in adults is unknown, with evidence limited to case reports and small series.<sup>11-68</sup>

## How are children with abdominal migraine managed?

### General and psychosocial approaches

A clear diagnosis<sup>3</sup> and explanation of the condition to the patient and family is essential (see information sheets in appendix on bmj.com).<sup>2,3</sup> In an observational clinic study, 60% of patients had parents with the same condition who were also relieved to understand it.<sup>3</sup> Labelling abdominal migraine as medically unexplained<sup>69</sup> or psychogenic pain<sup>49,70</sup> may exacerbate depression and anxiety in the child and parents. Missing the diagnosis<sup>5,14</sup> led to unsuccessful surgery (mainly appendicectomy) in 4%<sup>3</sup> and 5%<sup>5</sup> of patients with abdominal migraine in British and Indian hospital series.

The biopsychosocial model of pain and symptom management emphasises a holistic view of the patient's life.<sup>6,9</sup> Cognitive behavioural therapy improved functional abdominal pain in a case controlled series,<sup>71</sup> but there are no specific data for abdominal migraine. Dietary treatments and elimination diets are unproved.<sup>11</sup> Anecdotally, understanding or avoidance of triggers (such as acute emotional stresses, missed meals, and sleep loss) is helpful.<sup>3,22</sup> Acute symptoms resolve in >80% of patients with rest in a dark quiet room and simple analgesia (see Boxed Text on page 3 box 2, and ↓ on bmj.com).<sup>2</sup>

Box 2 Management strategies for abdominal migraine (see ↓ on bmj.com for supporting evidence)

#### General

- Explanation and education of patient and family (avoid triggers, regular lifestyle)<sup>2,3\*</sup>

#### Acute

- Rest in dark, quiet room\*
- Simple analgesics such as paracetamol 15 mg/kg, ibuprofen 10 mg/kg\*
- Sumatriptan—10 mg intranasal (triptan, serotonin agonist)\*

#### Preventive treatment

- Pizotifen (serotonin agonist) 0.25 mg twice daily as syrup\*
- Propranolol (β blocker) 10-20 mg twice or three times daily
- Cyproheptadine (antihistamine) 0.25-0.5 mg/kg daily as syrup
- Flunarazine (calcium channel blocker) 5-7.5 mg/day
- Sodium valproate (anti-epileptic) 500 mg three times daily intravenous—in hospital
- Dihydroergotamine (ergot) 0.5 mg intravenous, further doses possible (up to mean total 7-9 mg over several days)—in hospital

\*Treatments can be given in primary care.

## Pharmacological approaches

The evidence for pharmacological treatment of abdominal migraine is limited. In studies of paediatric migraine headache, resolution rates of up to 66% are reported with placebo treatment,<sup>85</sup> so high quality randomised controlled trials are needed to confirm efficacy of active treatments.<sup>86</sup> Pizotifen is the only medication meeting this standard for abdominal migraine.<sup>87</sup> ↓ on bmj.com summarises current evidence for treatments. Acute treatments, and if needed, prevention with pizotifen, may be managed in primary care, and will be effective in most patients. Expert advice is recommended for other medications because data are limited (cyproheptadine, propranolol, flunarazine, sodium valproate, dihydroergotamine) or absent (amitriptyline, topiramate) regarding use for abdominal migraine. It is unknown whether evidence on acute<sup>76</sup> or preventive management<sup>88</sup> of childhood migraine headache can be extrapolated to abdominal migraine. The only evidence for treatment of adult abdominal migraine is from case reports.<sup>68</sup>

#### Education into practice

- Does this article improve your confidence in making a positive diagnosis of abdominal migraine in those with recurrent abdominal pain? What might you ask or do differently?
- How might you better explain or offer advice to patients and families with abdominal migraine?

## Useful resources

- American Migraine Foundation\* <https://americanmigrainefoundation.org/understanding-migraine/abdominal-migraine/>
- Migraine Action\* [www.migraine.org.uk/](http://www.migraine.org.uk/)
- The Migraine Trust\* <https://www.migrainetrust.org/>
- Patient. Migraine in children\* <https://patient.info/doctor/migraine-in-children>
- The International Headache Society [www.ihs-headache.org](http://www.ihs-headache.org)
- The Rome Foundation [www.theromefoundation.org/](http://www.theromefoundation.org/)
- The American Headache Society <https://americanheadachesociety.org/>

\*Includes resources for patients and families

## How patients were involved in the creation of this article

Parents and a patient with abdominal migraine reviewed the information sheets and read the article, commenting on sections which they did not feel were clear (the initial description of abdominal migraine and how the diagnosis was made). These comments were used to improve the manuscript. The patient drew the original sketch for [fig 1](#).

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## Tables

**Table 1 | Red flag symptoms associated with childhood abdominal pain (adapted from Rome III16 and Rome IV9 classification)**

| Red flag symptom  | Common associated conditions                                 |
|---|--|
| <b>Acute</b>  |  |
| Features of dehydration or shock*                         | Any acute worsening pathology                                |
| Thirst, polyuria  | Diabetic ketoacidosis  |
| Localised pain with tenderness or guarding                | “Surgical” (appendicitis, volvulus, intussusception)         |
| Fever   | Infection (gastroenteritis† mesenteric adenitis)             |
| Vomiting bile   | Obstruction  |
| Vomiting blood  | Upper gastrointestinal bleed                                 |
| Bloody stool  | Gastrointestinal bleed, infection                            |
| Change in bowel habits (diarrhoea)                        | Gastroenteritis†   |
| Dysuria, haematuria                                       | Urinary tract infection                                      |
| Pain that radiates to the groin                           | Testicular torsion   |
| <b>Chronic or recurrent</b>                               |  |
| Odynophagia   | Tonsillitis, peritonsillar abscess                           |
| Dysphagia   | Reflux, developmental delay, metabolic, genetic              |
| Persistent right upper or right lower abdominal pain      | IBD, coeliac disease, malignancy                             |
| Abdominal mass  | Malignancy, storage diseases                                 |
| Persistent vomiting                                       | Reflux, cow's milk protein allergy, malignancy               |
| Weight loss   | IBD, coeliac disease, malignancy, metabolic, genetic         |
| Fever, night sweats                                       | Infection, IBD, malignancy                                   |
| Change in bowel habit (bloody stool or chronic diarrhoea) | IBD, coeliac disease, cow's milk protein allergy, malignancy |
| Growth failure and delayed puberty                        | IBD, malignancy, metabolic, genetic                          |
| Perianal abnormalities (fistulae, fissures, skin tags)    | IBD, coeliac disease   |
| Arthritis or family history of IBD                        | IBD  |

\*

NICE 2009<sup>21</sup> provides a table of progressive features of dehydration and shock.

†

Acute gastroenteritis needs urgent expert opinion if other red flags present.

Table 2| Treatment strategies for abdominal migraine in children

| Intervention  | Study type   | No of participants   | Outcome measures   | Duration  | Main results  | Safety* and availability  | Grade of evidence† <sup>72</sup>           |
|---|--|--|--|---|---|---|--|
| <b>General‡§</b>  |  |  |  |   |   |   |  |
| Explanation and education of patient and family (avoid triggers, regular lifestyle) <sup>2,3</sup>    | Case series in UK paediatric clinic aged 18 months to 15 years <sup>3</sup>                                  | 112 with abdominal migraine and/or cyclical vomiting (defined in Boxed Text on page 2box 1)  | Improvement, not otherwise specified   | Not specified   | 100% improvement, not further specified   | No adverse events   | Level 4                                    |
| <b>Acute treatment‡</b>   |  |  |  |   |   |   |  |
| Rest in dark, quiet room  | Observational study of random sample of Scottish schoolchildren aged 5-15 years <sup>2</sup>                 | 58 with abdominal migraine (Symon and Russell definition <sup>6</sup> )  | Resolution of acute episode of abdominal migraine  | Not specified   | 88% (51/58) resolved  | No adverse events   | Level 3                                    |
| Simple analgesics such as paracetamol 15 mg/kg, ibuprofen 10 mg/kg                                    | As above <sup>2</sup>  | As above   | Resolution of acute episode of abdominal migraine  | Acute, not further specified                                  | 38% (22/58) resolved  | No adverse events in this study. No difference between acute ibuprofen, paracetamol and placebo in adverse events in meta-analysis of children with pain or fever. <sup>73</sup> Paracetamol safe at recommended doses, hepatotoxic in overdose <sup>74</sup> | Level 3 (safety evidence is level 1 or 2)* |
| Sumatriptan 10 mg intranasal (triptan, serotonin agonist)¶  | Case reports, Japanese paediatric clinic <sup>75</sup>   | 12 year old girl with abdominal migraine (Rome III definition <sup>16</sup> ).<br>9 year old girl with abdominal migraine (Boxed Text on page 2box 1 definition) | Resolution of acute episode of abdominal migraine  | Acute, repeated over 2 years                                  | Acute pain responded (n=2)  | No adverse events in this study. Increased risk of minor adverse events in meta-analysis of paediatric migraine. <sup>76*</sup> Avoid overuse <sup>77</sup> (may cause rebound symptoms**) Licensed >12 years (UK), <sup>78</sup> >6 years (US) <sup>78</sup> | Level 4                                    |
| <b>Preventive treatment (consider if &gt;2 attacks/month or major impact despite acute treatment)</b> |  |  |  |   |   |   |  |
| Pizotifen (serotonin agonist) 0.25 mg twice daily as syrup‡ ¶ ††                                      | Randomised, double blind, placebo controlled, crossover trial, UK paediatric clinic <sup>79</sup>            | 14 patients, aged 5-14 years with abdominal migraine (Symon and Russell definition <sup>6</sup> )  | Days affected. Index of severity. Index of misery (severity × duration)  | 2 months in each crossover arm                                | Improvement: fewer days (4.29 v 12.5, P<0.005); severity lower (7.29 v 23.5, P<0.005); index of misery lower (25.43 v 81.5, P<0.007)  | Adverse events: mild drowsiness, weight gain (1.25 kg v 0.38 kg, P=0.035). Available worldwide but not licensed in US   | Level 1 or 2                               |
| Propranolol (β blocker) 10-20 mg two or three times daily   | Retrospective clinic case note review in US paediatric gastroenterology clinic, 3-15 years old <sup>15</sup> | 24 patients with abdominal migraine (Boxed Text on page 2box 1 definition)   | Responses: graded as excellent (pain-free), fair (improved but not resolved), or poor (no response). No of episodes in preceding 6 months versus 6 months' treatment | Duration as required: 3-6 months for 11/24, 3 years for 13/25 | 75% (18/24) excellent, 8% (2/24) fair, 17% (4/24) poor. Two responded to cyproheptadine. Mean (SE) No of episodes in preceding 6 months 5.4 (0.6) versus 1.0 (0.3) in 6 months' treatment | Adverse events: shortness of breath (1/24), headache (1/24), drowsiness (1/24). Asthma is contra-indication. Expert guidance recommended  | Level 3 or 4                               |
| Cyproheptadine (antihistamine) 0.25-0.5 mg/kg daily as syrup‡‡  | As above <sup>15</sup>   | 12 patients with abdominal migraine (Boxed Text on page 2box 1 definition)   | As above   | Duration as required: 2-11 months                             | 33% (4/12) excellent, 50% (6/12) fair, 17% (2/12) poor. Mean (SE) No of episodes in preceding 6 months 5.8 (2.1) versus 1.3 (0.5) in 6 months' treatment                                  | Adverse events: drowsiness (1/12), weight gain (1/12). Expert guidance recommended  | Level 3 or 4                               |

Table 2 (continued)

| Intervention  | Study type  | No of participants  | Outcome measures   | Duration  | Main results   | Safety* and availability                                       | Grade of evidence†‡ |
|---|---|---|--|---|--|--|---------------------|
| Flunarazine (calcium channel blocker) 5-7.5 mg/day††  | Uncontrolled trial, US paediatric clinic <sup>80</sup>  | 10 patients with abdominal migraine   | Percentage reduction in frequency and duration                         | 6-24 months (mean 13 months)  | Frequency reduction 61%, duration reduction 51% (headache reduction 60%) | Expert guidance recommended                                    | Level 3             |
| Sodium valproate (antiepileptic) 500 mg three times daily intravenous¶                                    | Case studies, in US paediatric hospital <sup>81</sup>   | 2 girls, 12 and 17 years old, with intractable abdominal migraine (Russell et al definition <sup>10,82</sup> )                  | Cessation of refractory episode and associated behavioural disturbance | Episodic treatment when other treatments including sumatriptan failed | Episodes resolved  | Adverse events: weight gain (1/2). Expert guidance recommended | Level 4             |
| Dihydroergotamine (ergot) 0.5 mg intravenous, further doses (mean 7-9 mg total over several days) ¶ †† §§ | Case series, US hospital (joint gastroenterology, neurology and autonomic departments <sup>83</sup> ) | 6 patients, 13-19 years, intractable abdominal migraine, unresponsive to amitriptyline, verapamil, topiramate, sodium valproate | Cessation of refractory episode<br>Time to next episode                | Episodic treatment  | 5/6 responders   | No significant adverse events<br>Expert guidance recommended   | Level 4             |

\*

Safety derived from abdominal migraine studies and other studies in paediatrics.

†

Evidence grades 1-5 (highest to lowest).

‡

Treatments can be given in primary care.

§

See information leaflets in appendix on bmj.com.

¶

Caution in females of childbearing age.

\*\*

Medication overuse in children: acute analgesics >3 days/month and migraine-specific drugs, especially triptans, >9 times/month.<sup>7-84</sup>

††

Availability limited in some parts of world.

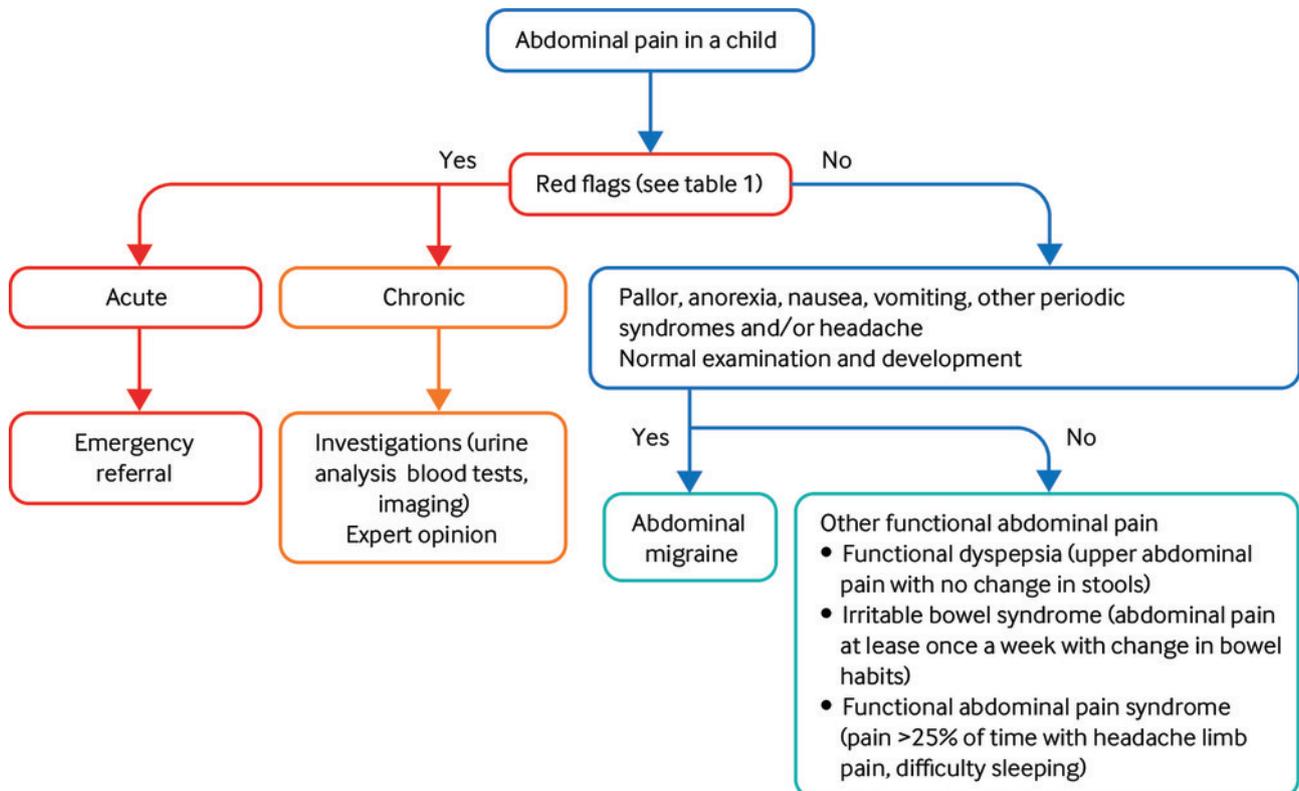
‡‡

Little used in some parts of world.

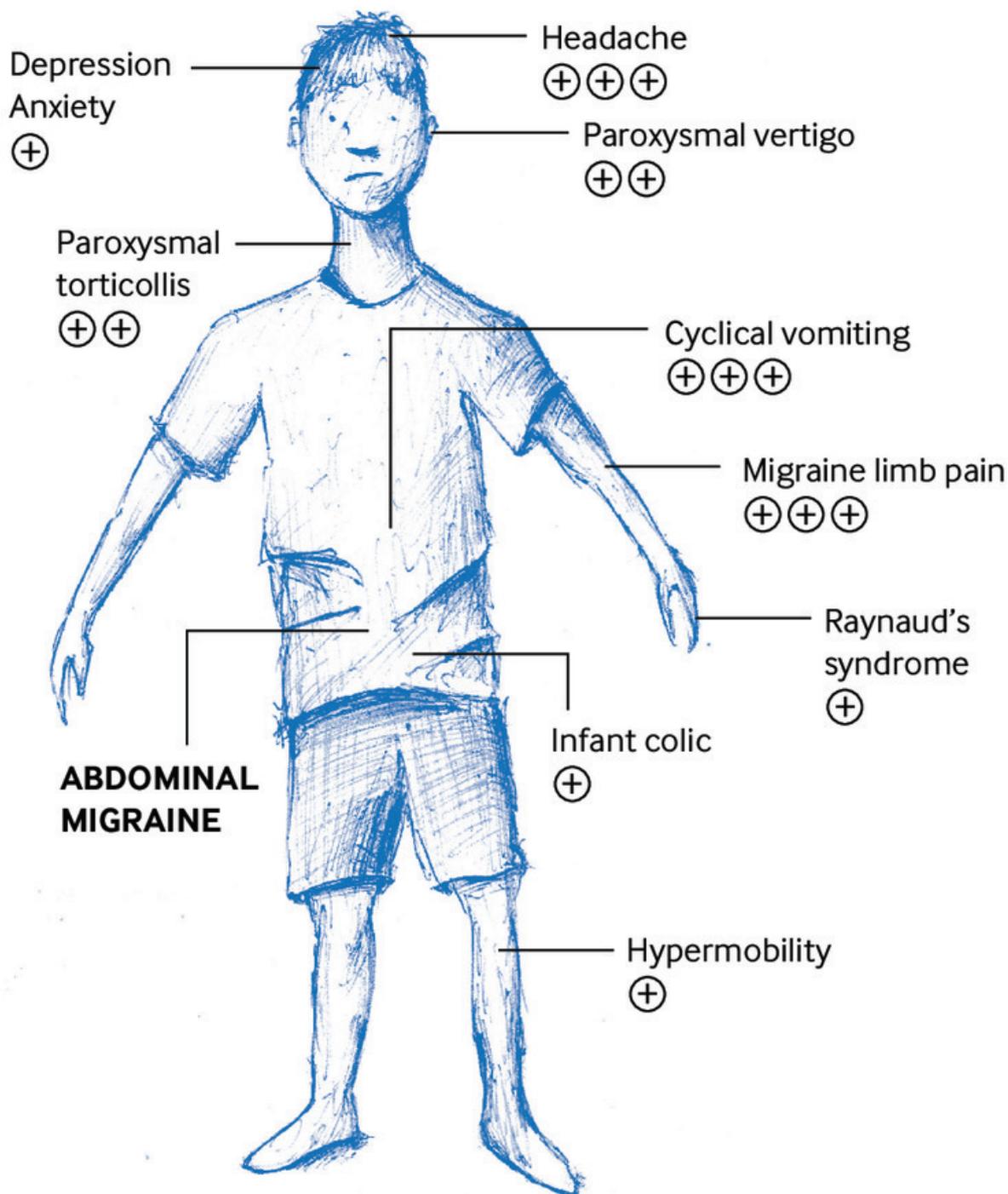
§§

Not licensed for children in UK.

## Figures



Schematic approach to managing abdominal migraine (adapted from Rome III,<sup>16-19</sup> Rome IV<sup>9</sup> and ICHD-3 classifications,<sup>7</sup> and Quek, 2015<sup>20</sup>)



Strength of evidence for associations: + uncertain, ++ moderate, +++ strong association<sup>1</sup>

A patient's view of the associations of abdominal migraine and level of evidence for these