International Foundation for Functional Gastrointestinal Disorders
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Functional Dysphagia

Adapted from IFFGD's *Functional Gastrointestinal Disorders Education Program Guide*, Chapter Five: *Functional Esophageal Disorders*. By: Joel Richter, M.D., Chair, Department of Gastroenterology, Professor of Internal Medicine, The Cleveland Clinic Foundation, Ohio

Functional esophageal disorders represent a combination of chronic or recurrent symptoms affecting the esophagus. They are not attributable to an underlying anatomic problem or significant motility disorder. They are termed as "functional" disorders because no inflammatory, infectious, or structural abnormality is observed by examination, x-ray, or laboratory test.

Functional dysphagia is the *sensation* of solid and/or liquid foods sticking, lodging, or passing abnormally through the esophagus. It is diagnosed based on symptoms present for at least three months and not associated with anatomic abnormalities, gastroesophageal reflux disease (GERD), or well recognized motility disorders such as achalasia [difficulty swallowing due to an absence of peristaltic contractions in the esophagus]. Prevalence of functional dysphagia is unknown and generally it has been poorly studied. The disorder is usually accompanied by other symptoms of esophageal dysfunction including chest pain, heartburn, and regurgitation.

Tests

In clinical practice, the presence of structural lesions are first excluded with barium x-rays and endoscopy. Manometry, a test that measures pressure in the esophagus, is next performed looking for evidence of achalasia and other disorders that may affect the movement of foods or liquid through the esophagus. In cases of functional dysphagia, 24-hour pH monitoring is generally reserved for individuals where the history is particularly suggestive of reflux disease, such as persistent heartburn. A balloon distention test may be performed to determine if heightened sensitivity, or abnormal sensory perception within the esophagus, may be contributing to symptoms. A feeling described as "food sticking" as well as pain can be produced more easily in some people if heightened sensitivity is present.

Treatment

For mild symptoms, avoidance or reduction of foods that worsen symptoms is recommended. Chewing food thoroughly during meals may also help. If GERD is present, medications to inhibit or prevent acid reflux will be prescribed. Treatment will also be directed at any esophageal motility disorder that may be present.

Treatment varies for more severe or painful symptoms. Depending on the severity of pain, therapies aimed at improving the motility of the esophagus and reducing symptoms may include medications that: 1) relax the sphincter muscles of the esophagus, 2) improve esophageal contractions and movement of food, or 3) decrease heightened sensitivity.

Symptoms of dysphagia usually improve over time. Surgery is rarely undertaken for patients with functional dysphagia.

Doctor-Patient Partnership

Functional dysphagia is a very real disorder where the primary abnormality is an altered physiological function. There are many factors that can affect the functioning of the esophagus.

A person with symptoms of functional dysphagia, working with their physician, can help develop an individualized treatment plan. It is often helpful to keep a diary for several weeks to record symptoms, when they occur, diet, as well as circumstances that may be affecting daily life. This can assist both the individual and the physician to recognize factors that may contribute to symptoms. Taking an active role in treatment can often help a person to achieve the best possible outcome.

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Dyspepsia—Upper Abdominal Pain

By: Nicholas J. Talley, MD, PhD, Professor of Medicine, University of Sydney, Australia

One of the most common symptoms is pain or discomfort in the upper abdomen. It is known that one in four people in the community have upper abdominal distress at times. This can be caused by a large number of medical conditions, including peptic ulcer disease, gallstones, esophageal inflammation (esophagitis), and cancer, to name the major conditions. However, there remain a large number of people who after being investigated have none of these medical conditions. Indeed, there is no obvious cause for their symptoms. Patients who have this type of dyspepsia are referred to as suffering from functional dyspepsia.

Cause

The cause of this condition is not clear. Gastric acid does not appear to be of major importance, as acid secretion is not increased in people with functional dyspepsia. Up to half of those with functional dyspepsia, however, do have slow gastric emptying. In addition, a proportion of patients has a sensitive stomach. If a balloon is placed into the stomach and distended, some patients with functional dyspepsia develop sensations with the balloon at lower pressures than people without this problem.

Stress may play a role. It is known that acute stress can affect emptying of food from the stomach, slowing it down. However, the exact relationship between stress and functional dyspepsia remains unclear. Anxiety and depression may be present in some patients with dyspepsia and may contribute to the symptoms.

Sometimes drugs, including aspirin and arthritis medicines, are implicated though many people with functional dyspepsia are not taking such drugs. On the other hand, smoking and alcohol appear not to be important in this condition. About one third of patients with unexplained dyspepsia also have irritable bowel syndrome, so more generalized motility disturbances may be important in some cases.

Once a diagnosis of functional dyspepsia has been made, it is important for the patient to realize that this is a real condition but that it is not life threatening. Some patients find that their symptoms disappear over time for unexplained reasons. Many patients continue to have symptoms on and off over the long term, and some even experience them more frequently, although this is less common.

Treatment

It may be helpful for patients to consider changing their diet when they have this condition. Small, regular, low-fat meals can be helpful in some situations. Stress reduction techniques can also be very helpful, especially relaxation therapy. Medications have a small role to play in the management of the condition. Drugs that reduce acid secretion and antacids are probably not of major help in many patients with functional dyspepsia, even though these drugs *are* useful in peptic ulcer and esophagitis. Drugs that speed up movement of food from the stomach to the intestine and through the small intestine may be helpful, as they have been shown in well-conducted trials to be superior to placebo preparations. The benefit of other treatments remains to be shown in properly conducted scientific studies and cannot be generally recommended at this time.

In conclusion, functional dyspepsia is a common and important condition that has a good prognosis. More research needs to be undertaken to find the causes of this condition and define better treatments for those who have more intractable symptoms.

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Anorectal Pain (160) Copyright © 2001 by the International Foundation for Functional Gastrointestinal Disorders

Proctalgia Fugax—and Other Pains

By: W. Grant Thompson, MD, Emeritus Professor of Medicine, University of Ottawa, Canada

"...dull, throbbing, tearing, sickening pain comparable to nothing on earth—one feels as though a hard stone in the rectum was wanting to get out."
– Anonymous sufferer of proctalgia fugax

Many diseases of the anus and rectum may cause severe rectal pain. Usually a doctor can identify such a condition by examining the area. One pain that cannot be so identified is that with the Greco-Roman moniker, *proctalgia fugax*. This is a sudden, severe pain in the region of the rectum and anus that lasts several minutes and then disappears completely. Even if the victim's nether region is examined during an attack of pain, no consistent abnormality has been identified. Despite the sometimes excruciating pain, the proctalgia fugax sufferer is perfectly well, once the attack has subsided.

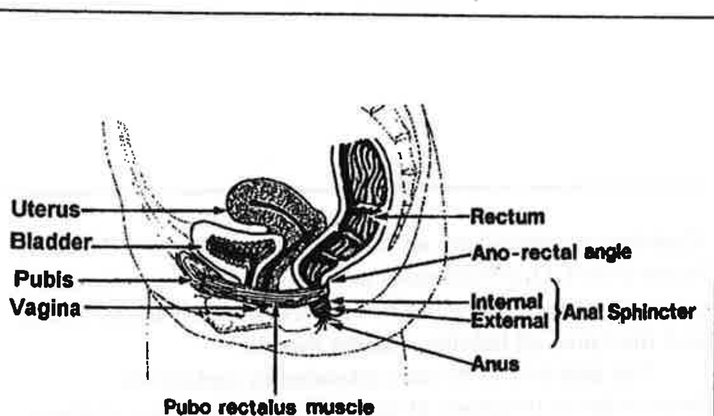

FIGURE 1 – MUSCLES OF THE PELVIC FLOOR
The puborectalis muscle extends from the pubic bone as a sling around the rectum. It tends to pull the rectum forward creating an anorectal angle that assists in preventing incontinence. Spasm of this muscle is believed by some to be responsible for the fleeting pain of proctalgia fugax.

This puzzling phenomenon is reported in 5 to 15% of respondents in population surveys. Many years ago it was described as a, "male condition, even a doctor's disease," since only male doctors had the temerity to report their bewildering experiences in the pages of medical journals. For most, the pain is so fleeting that it seldom reaches medical attention. Thanks to surveys, we now know that proctalgia fugax is actually more prevalent in women than in men.

Nevertheless, many of you readers must have experienced the pain and wondered, "What was that?!" No doubt, the pain can be very severe. Some equate it with the pains of childbirth or a gallbladder attack, and it has been known to cause one to faint. Nevertheless, the pain of proctalgia fugax is mercifully brief. It occurs without warning, often when one is in a deep sleep. Some individuals report that it follows sexual activity. The pain is felt deep in the rectum, usually midline, but occasionally favoring one side. It has been described as "searing," "cramping," "stabbing," "grinding," and "gnawing." Attacks seem to average about 6 per year. In some it is much less frequent, and in others it may occur in clusters. Unlike the several painful physical diseases of the anus, the pain does not coincide with defecation. Indeed, it seems that the attack may end with the passage of a little gas or stool. At one time, this pain was thought to be associated with irritable bowel syndrome or constipation, but it now appears that there are no associated conditions, and no risk of serious complications.

There are several suggested causes. Spasm of the muscular walls of the anus or rectum was suspected, but has not consistently been seen to coincide with an attack. To say the least, testing for abnormalities in the bottom of a person with such a transient condition is difficult. Several physician-

sufferers have examined themselves during an attack and report a painful band of muscle pressing on the sides and back of the rectum. This suggests that proctalgia fugax is not an anorectal problem at all, but rather one of spasm of the puborectalis muscle. This muscle is a sling from the pubic bone that supports the anorectal angle, and normally relaxes during defecation (Figure 1). It is not an intestinal muscle at all, but rather a skeletal muscle similar to the muscles of the arm. If all this is true, then proctalgia fugax is but a "charlie horse" (or muscle cramp) of the backside.

There are studies that link proctalgia fugax to emotional stress. However, cause can be confused with effect. Moreover, the data suffer from "referral bias" in that most individuals do not see doctors for the condition, and are excluded from study.

Whatever the cause, sufferers should be confident that the pain is not an indication of something more serious. The typical spontaneous, infrequent, transient occurrences require no medical attention. However, if there are other symptoms or the attacks are frequent and lengthy, a doctor should examine the anorectum. The area where the pain occurs is very sensitive and disease there can cause excruciating pain. Typically, however, pain due to anal pathology [disease or structural abnormality] is unrelenting, or aggravated by the passage of a stool. An anal fissure, for example is a small tear, like a paper cut, in the anal canal. It may be difficult for the doctor to see, but the stretching and chemical effects of a passing stool elicits severe pain due to reflex spasm of the anal sphincter muscle. Other diseases may include anal ulcers, fistulas, or abscesses that are outside the scope of this article. (See "*What Do you Do After...*" IFFGD Fact Sheet No. 137.)

When the anal pain is persistent and no abnormality can be seen on examination, the condition is known as *levator syndrome*. This phenomenon is as puzzling as proctalgia fugax, but in this case the pain is chronic and may intrude into a person's life. If the pain occurs frequently, lasts for hours and interferes with living, it is wise to discuss the problem with a doctor.

By the time an attack of proctalgia fugax is treated, the pain has usually subsided of its own volition. Nevertheless, many cures have been advocated, including nitroglycerine, anti-epileptics and psychoactive drugs. None has a rationale, and none can be recommended. One small trial showed that inhaling salbutamol, a drug used for asthma, shortens attacks of proctalgia fugax. If you have severe lengthy attacks, you may wish to discuss the use of this drug with your doctor. For most of us, such treatment would be therapeutic overkill.

The most enduring treatment is the application of pressure to the anorectal area. This may be done manually, or by sitting on the edge of a table or counter. The attacks are usually so infrequent that the use of medication to prevent attacks would be impractical, even if such a medication existed. The best management is to exclude the diseases briefly mentioned above, allow time, and be secure that nothing more serious will ensue.

[For more information about pelvic floor pain refer to IFFGD Fact Sheet No. 109, *Disorders Related to Excessive Pelvic Floor Muscle Tension*.]

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