Functional nausea

Chronic nausea syndrome: frequent nausea that is real, disruptive and not fully explained by another condition.

i Rome V now uses the term chronic nausea syndrome for the condition previously called functional nausea. Your clinician may use either term. The important point is that this is a positive diagnosis after an appropriate assessment - not a label meaning “nothing is wrong”.

What does it feel like?

Nausea is the unpleasant feeling that you might vomit. In chronic nausea syndrome, nausea is the main symptom and occurs at least twice a week. Under current Rome V paediatric criteria it is not associated with vomiting, although some children may have other gut-brain symptoms at different times.

Nausea may be strongest in the morning, during travel, around school or stressful events, or at apparently random times. Some children also notice dizziness, sweating, pallor, a fast heartbeat, headaches, bloating or altered bowel habits.

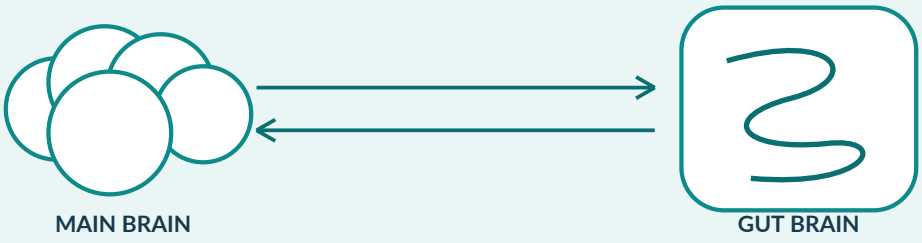
The symptom is real

The stomach, gut nerves, autonomic nervous system and brain constantly exchange signals. Those systems can become unusually sensitive even when scans, blood tests or endoscopy do not show injury. Anxiety or stress can amplify nausea, but they are not required for the diagnosis and do not make symptoms imaginary.

Why can nausea persist?

Several mechanisms can overlap in the same child or adolescent.

The most useful model is a gut-brain-autonomic system rather than a single “stomach problem”.



MAIN BRAIN
sleep • stress • anticipation
can turn up pain processing

GUT BRAIN
gas • stretch • constipation
can turn up gut sensitivity

Messages travel both ways - treatment can target both ends.

Common overlaps

Functional dyspepsia can cause meal-related fullness, early satiety or upper abdominal discomfort with nausea. Gastroparesis can feel similar, but requires objective evidence of delayed stomach emptying when that test is clinically indicated.

Some young people have orthostatic intolerance: nausea, dizziness, palpitations or weakness when upright. Postural orthostatic tachycardia syndrome (POTS) is a separate diagnosis and should not be assumed from nausea alone.

Constipation, migraine biology, poor sleep, post-infectious changes and fear of symptoms can all increase the volume of the nausea signal.

Overlap is common. A child can have chronic nausea syndrome plus constipation, migraine, functional dyspepsia or an autonomic disorder. Treatment should target the parts of the pattern that are actually present.

Assessment and red flags

Test for a reason - and reassess if the pattern changes.

What the clinician looks for

The history includes timing, meals, vomiting, stool pattern, pain, headaches, dizziness on standing, sleep, medicines and supplements, weight trend and school impact. Older adolescents may also be asked privately about pregnancy possibility, cannabis or other substances when clinically relevant.

Growth and examination matter. Basic blood, urine, coeliac, inflammation or other tests are chosen when the history suggests them; there is no single blood test that proves chronic nausea syndrome.

When might specialist tests help?

Gastroscopy is not routine for isolated functional nausea, but can be useful for bleeding, persistent vomiting, swallowing difficulty, weight loss, abnormal blood or stool tests, or another concern for upper gastrointestinal disease.

A gastric emptying study is considered when persistent vomiting, marked early fullness or retained-food symptoms make gastroparesis plausible. Orthostatic heart rate and blood pressure assessment can help when standing triggers dizziness, tachycardia or faintness.

! Urgent assessment: green vomit, vomiting blood, a swollen or rigid abdomen, severe new focal pain, fainting, marked dehydration, confusion, new neurological symptoms or a child who appears very unwell. Progressive weight loss, persistent vomiting, dysphagia or worsening symptoms need prompt review.

Everyday treatment

Reduce the nausea burden without letting life become progressively smaller.

Regular fuel

Aim for predictable meals or small snacks rather than long fasting followed by a large meal. If mornings are hardest, start gently and build intake across the day.

Hydration

Regular drinks can help, especially when dizziness accompanies nausea. An individual orthostatic plan may include extra fluid or salt only when advised by the treating team.

Sleep & movement

Keep a consistent wake time and gradually restore enjoyable activity. Deconditioning, poor sleep and long periods in bed can amplify autonomic and gut-brain symptoms.

Treat constipation

Retained stool can increase fullness, bloating and nausea. Keep stools soft and comfortable when constipation is present.

Avoid a shrinking “safe” diet

Repeated nausea can make a young person afraid to eat. Avoid removing multiple food groups without a clear reason. A paediatric dietitian is particularly helpful with weight loss, food avoidance or an already narrow diet.

Make school workable

Agree on water access, a brief quiet recovery space, permission for a small snack if needed, and a plan to return to class rather than going home for every familiar flare. Progress may show first as better attendance, eating and activity before nausea disappears.

> “ A useful treatment goal is better function: more reliable eating, less fear, fewer missed activities and faster recovery from flares - not necessarily zero nausea every day.

Skills that calm the nausea circuit

Gut-brain treatment is active treatment, not a suggestion that symptoms are psychological.

Approach	What it does	When it may fit
Gut-directed hypnotherapy	A paediatric randomised trial found benefit for chronic functional nausea; in the functional-nausea subgroup it outperformed standard medical treatment during the early follow-up period.	Strong option to discuss, especially when symptoms are persistent.
CBT / gut-brain therapy	Builds skills for symptom fear, attention, coping, sleep and gradual return to eating, school and activity.	Particularly useful when avoidance, anxiety or disability has grown around symptoms.
Breathing / relaxation	Slow breathing and relaxation can reduce autonomic arousal and give the child a practical tool during a familiar flare.	Use as a skill, not as proof the symptom is “stress”.
Graded re-engagement	A planned return to meals, movement and school helps reverse deconditioning and symptom-driven avoidance.	Progress should be gradual and medically safe.

i If dizziness, tachycardia or faintness on standing is prominent, treat confirmed orthostatic intolerance alongside the nausea. That may involve hydration, conditioning and other measures directed by the clinician; not every child with nausea has POTS.

TRUSTED INFORMATION & EVIDENCE

Randomised trial: hypnotherapy vs medical treatment for paediatric functional nausea ↗

Rome V paediatric chronic nausea criteria ↗

Medicines: choose for the pattern

No single medicine is proven for every child with chronic nausea.

Option	When it may fit	Important limitations
Cyproheptadine	Selected children with nausea, early fullness or poor appetite.	Paediatric evidence is mostly observational. Sleepiness, increased appetite, weight gain or irritability can occur.
Mirtazapine	Selected older children/adolescents, especially when nausea coexists with weight loss, poor sleep or anxiety.	A paediatric retrospective series reported frequent improvement, but this is not placebo-controlled evidence. Weight gain, sleepiness or mood effects need review.
Ondansetron	Short-term rescue for significant nausea/vomiting in selected situations.	Evidence for chronic functional nausea is sparse. Constipation, interactions and rhythm risk matter.
Amitriptyline / neuromodulators	Sometimes used when nausea overlaps with persistent gut pain or another gut-brain disorder.	Nausea-specific evidence is limited. Specialist review of side effects, interactions, mood and cardiac risk is important.
Acid suppression / prokinetics	Only when another feature suggests an acid-related disorder or a motility problem.	They are not routine treatment for chronic nausea syndrome itself. A prokinetic does not make sense simply because nausea is present.

Use one or two well-chosen treatments with a clear target and review date. Avoid endlessly stacking anti-nausea medicines or supplements when the diagnosis and goals have not been revisited.

TRUSTED INFORMATION & EVIDENCE

Mirtazapine paediatric retrospective study ↗
Cyproheptadine paediatric dyspepsia/nausea study ↗
Rome V paediatric upper DGBI review ↗



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Please avoid including your child's name or private health information in a public review.