Gastroparesis in children

When the stomach empties more slowly than it should.

Gastroparesis means delayed stomach emptying without a physical blockage. Symptoms alone cannot confirm it. The plan protects nutrition, eases symptoms and addresses any contributing cause.

What might my child experience?

Feeling full early, fullness lasting long after food, nausea, vomiting, bloating or upper tummy pain. Vomiting may contain food eaten earlier. Severe symptoms can affect hydration, weight and school participation.

How does the stomach usually work?

The upper stomach holds a meal while the lower part mixes and grinds it. Coordinated contractions move food through the outlet, called the pylorus, into the small bowel. Nerves, muscle and the outlet need to work together.



STOMACH

Mixes and grinds food

Emptying is slower

Food can be retained for longer; a blockage must be excluded.

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Why does it happen?

It can follow an infection, occur with another medical condition, be affected by some medicines, or have no clear cause. Diabetes can cause gastroparesis, but is not the explanation for most children. Some post-infectious cases improve over time.

Tests and the gut-brain connection

Check emptying, consider other causes and interpret results in context.

How do we confirm it?

A gastric emptying study measures how quickly a standard meal leaves the stomach. A scan often follows the meal over several hours, commonly four. The test must suit the child's age and ability to eat the meal. The team gives instructions about fasting and which medicines to hold; do not stop medicines on your own.

What is the role of endoscopy?

Gastroscopy or imaging may be needed to rule out blockage or another disease. Endoscopy cannot by itself measure stomach emptying. Retained food at a scope is a clue, not a complete diagnosis. Blood tests are selected for nutrition and possible causes.

Why can symptoms and scan results differ?

Stomach sensitivity and how comfortably it relaxes for a meal also matter. A child can have marked symptoms with only mild delay, or similar symptoms with normal emptying, as in functional dyspepsia. Both can require treatment, but they are not the same diagnosis.

The "two brains"

The stomach's own nerves - the "gut brain" - communicate with the main brain. A sensitive gut may feel normal stretch as discomfort: this is visceral hypersensitivity. Repeated symptoms can also turn up the brain's pain-processing "volume". These processes may coexist with delayed emptying; they do not make the symptoms imaginary.

> **i** Treatment can support movement, nutrition and the response to symptoms. Gut-brain therapy may help coping or food-related fear, but does not prove that delayed emptying has resolved.

TRUSTED INFORMATION AND SOURCES

Children's Hospital of Philadelphia - gastroparesis ↗

Paediatric gastroparesis evidence review ↗

Eating and protecting growth

Use a dietitian-guided plan that your child can actually manage.

Smaller, more frequent meals

Several small meals or snacks are often easier than a few large meals. Chew well and eat slowly. Soft, well-cooked foods or foods blended into small particles may be better tolerated. Liquids can be easier for some children, but should still provide adequate nutrition.

Fat and fibre: adjust, do not simply eliminate

Very fatty meals and large amounts of coarse fibre can be harder to tolerate. A dietitian can adjust texture and distribution while preserving calories, essential fats, fibre balance and vitamins. A very restrictive or prolonged liquid-only diet should not be started independently.

What about FODMAPs?

Low FODMAP does not treat delayed emptying. Consider it only for a separate IBS-like stool and bloating pattern, with dietitian advice. Avoid unnecessary extra restriction.

Hydration and daily habits

Offer regular drinks and gentle post-meal movement; avoid lying flat straight after eating. Treat constipation. If diabetes is present, coordinate care with the diabetes team.

If intake is not enough

Oral supplements may help. Severe cases sometimes need small-bowel tube feeding. Intravenous nutrition is reserved for when feeding through the digestive tract is insufficient or impossible.

> **i** Seek early dietitian review for weight loss, poor growth, low energy, repeated dehydration or escalating food avoidance. The goal is nourishment and participation, not a progressively smaller list of “safe” foods.

NIDDK - eating strategies for gastroparesis ↗

Medicines and other treatments

Paediatric evidence is limited; use specialist-supervised trials.

Prokinetics: helping movement

These medicines aim to improve stomach contractions or emptying. Erythromycin may help for a period, but benefit can fade and it has interactions and heart rhythm risks. Domperidone is sometimes considered, with careful assessment of rhythm risk and other medicines; paediatric use is not routine.

Metoclopramide

It may improve movement and nausea, but abnormal movements and potentially lasting movement disorders limit its use in children. It requires a clear specialist plan.

Antiemetics: helping nausea and vomiting

Ondansetron may reduce vomiting but does not make the stomach empty faster. It can cause constipation; rhythm risk and interactions need consideration in selected children. Choice and timing depend on the child and symptoms.

Medicines for appetite or sensitivity

Cyproheptadine may be used for nausea or early fullness; evidence is observational and it is not a proven stomach-emptying treatment. Sleepiness and weight gain can occur. Amitriptyline may target pain in selected gut-brain disorders, but is not established treatment to speed emptying and may worsen motility in some patients.

Probiotics, peppermint and procedures

Probiotics and peppermint lack good evidence for paediatric gastroparesis. Peppermint may worsen reflux. Botox, pyloric procedures and gastric electrical stimulation are specialist options for severe cases, with uncertain paediatric benefit.

i Agree on a goal and review date. Opioids can slow emptying and are generally avoided. Doses require an individual plan.

NIDDK - treatment overview ↗

Living well while symptoms improve

Support school, confidence and a realistic follow-up plan.

School and home

Arrange time for small meals, water and prescribed treatments. Use a discreet plan for nausea and missed work. A short break followed by return to activity can help when medically safe. Do not force activity during dehydration or severe vomiting.

Psychological support

A child-experienced psychologist can help with nausea-related fear, coping and gradual return to eating or school. This supports physical treatment. Evidence for Nerva and gut-directed hypnotherapy is mainly in IBS; the app is not an established treatment for delayed stomach emptying.

What should we track?

Note meal tolerance, vomiting, fluids, bowel pattern, treatment effects and school participation. The treating team monitors growth and nutrition. Better eating and fewer admissions can matter even before symptoms disappear.

What is the outlook?

Some children, especially after infection, improve substantially. Others need longer-term management. Recovery varies, and the degree of delay on one scan does not reliably predict every child's course.

! Urgent care: green or bloody vomit, severe new pain or swelling, fainting, very little urine, inability to keep fluids down, unusual drowsiness or a very unwell child. Do not assume these are just gastroparesis.

TRUSTED INFORMATION AND SOURCES

Children's Hospital of Philadelphia - paediatric care ↗

Children's National - gastroparesis in children ↗



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