CORSO
INTERREGIONALE
A.I.G.O.

LA NUOVA GASTROENTEROLOGIA

EMILIA ROMAGNA
MARCHE
TOSCANA

I disturbi funzionali: il corpo e la mente

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PSICÓLOGO

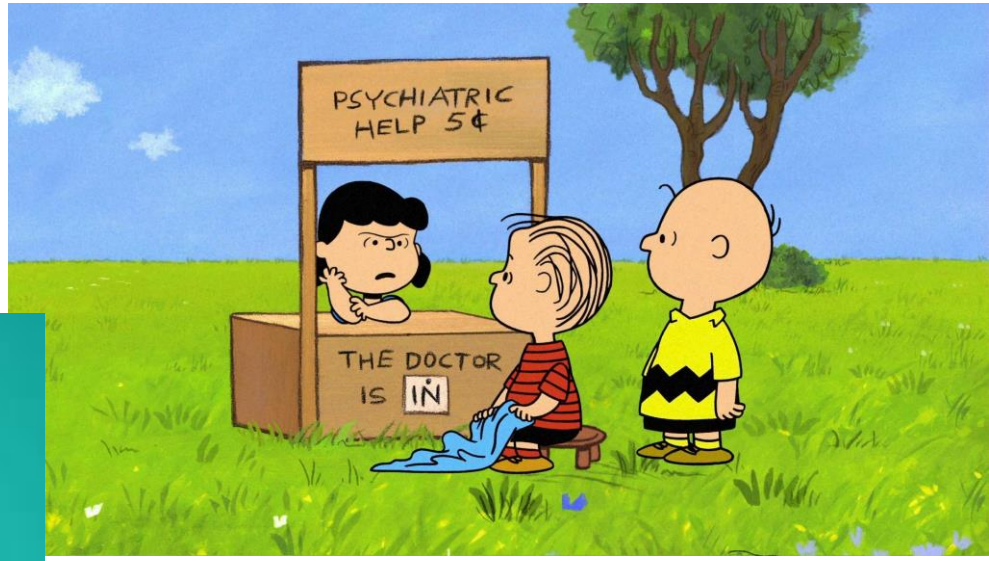

PSYCHIATRIC
HELP 5¢
THE DOCTOR
IS IN

Table 2. Functional Gastrointestinal Disorders: Disorders of Gut–Brain Interaction

A. Esophageal Disorders

A1. Functional chest pain
A2. Functional heartburn
A3. Reflux hypersensitivity
A4. Globus
A5. Functional dysphagia

B. Gastroduodenal Disorders

B1. Functional dyspepsia
  B1a. Postprandial distress syndrome (PDS)
  B1b. Epigastric pain syndrome (EPS)
B2. Belching disorders
  B2a. Excessive supragastric belching
  B2b. Excessive gastric belching
B3. Nausea and vomiting disorders
  B3a. Chronic nausea vomiting syndrome (CNVS)
  B3b. Cyclic vomiting syndrome (CVS)
  B3c. Cannabinoid hyperemesis syndrome (CHS)
B4. Rumination syndrome

C. Bowel Disorders

C1. Irritable bowel syndrome (IBS)
  IBS with predominant constipation (IBS-C)
  IBS with predominant diarrhea (IBS-D)
  IBS with mixed bowel habits (IBS-M)
  IBS unclassified (IBS-U)
C2. Functional constipation
C3. Functional diarrhea
C4. Functional abdominal bloating/distension
C5. Unspecified functional bowel disorder
C6. Opioid-induced constipation

D. Centrally Mediated Disorders of Gastrointestinal Pain

D1. Centrally mediated abdominal pain syndrome (CAPS)
D2. Narcotic bowel syndrome (NBS)/
  Opioid-induced GI hyperalgesia

E. Gallbladder and Sphincter of Oddi (SO) Disorders

E1. Biliary pain
  E1a. Functional gallbladder disorder
  E1b. Functional biliary SO disorder
E2. Functional pancreatic SO disorder

F. Anorectal Disorders

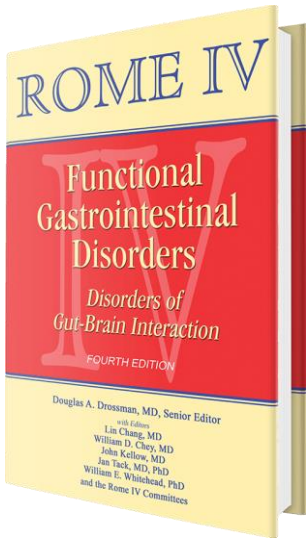
F1. Fecal incontinence
F2. Functional anorectal pain
  F2a. Levator ani syndrome
  F2b. Unspecified functional anorectal pain
  F2c. Proctalgia fugax
F3. Functional defecation disorders
  F3a. Inadequate defecatory propulsion
  F3b. Dyssynergic defecation

G. Childhood Functional GI Disorders: Neonate/Toddler

G1. Infant regurgitation
G2. Rumination syndrome
G3. Cyclic vomiting syndrome (CVS)
G4. Infant colic
G5. Functional diarrhea
G6. Infant dyschezia
G7. Functional constipation

H. Childhood Functional GI Disorders: Child/Adolescent

H1. Functional nausea and vomiting disorders
  H1a. Cyclic vomiting syndrome (CVS)
  H1b. Functional nausea and functional vomiting
    H1b1. Functional nausea
    H1b2. Functional vomiting
  H1c. Rumination syndrome
  H1d. Aerophagia
H2. Functional abdominal pain disorders
  H2a. Functional dyspepsia
    H2a1. Postprandial distress syndrome
    H2a2. Epigastric pain syndrome
  H2b. Irritable bowel syndrome (IBS)
  H2c. Abdominal migraine
  H2d. Functional abdominal pain – NOS
H3. Functional defecation disorders
  H3a. Functional constipation
  H3b. Nonretentive fecal incontinence



The complex interplay between gastrointestinal and psychiatric symptoms in irritable bowel syndrome: A longitudinal assessment

Journal of Gastroenterology and Hepatology **34** (2019) 713–719

Cristina Stasi,[*,1] Anna Caserta,[†,1] Cristiana Nisita,[†] Sonia Cortopassi,[†] Bernardo Fani,[‡] Stefano Salvadori,[§] Andrea Pancetti,[‡] Lorenzo Bertani,[‡] Dario Gambaccini,[‡] Nicola de Bortoli,[‡] Liliana Dell'Osso,[†] Corrado Blandizzi,[¶] Santino Marchi[‡] and Massimo Bellini[‡]

Psychological distress is an important **risk factor** for the **development of FGIDs** and, when present, can perpetuate or **exacerbate** symptoms. Further, it affects the **doctor patient relationship** and negatively impacts **treatment outcomes**.

Comorbid anxiety and depression are independent predictors of post-infectious IBS and functional dyspepsia (FD)

However, **psychological distress can also be a consequence,** rather than a cause, of disease burden.

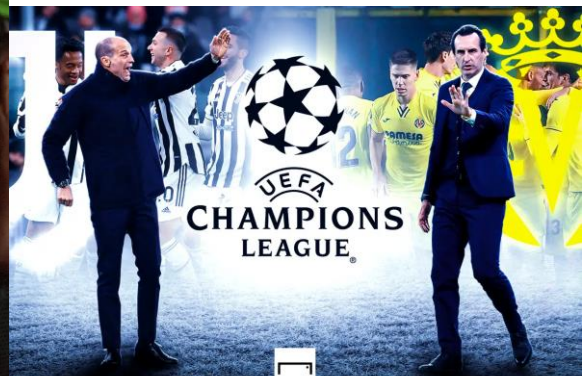
(Van Oudenhove L, 2016)

(Zamani, 2019)

Anxiety disorders occurr in 30- 50% of **FGID** patients.
They may **initiate or perpetuate** FGID symptoms through **heightened autonomic arousal** in response to stress, which can interfere with GI sensitivity and motor function.

(Van Oudenhove L, 2016)

Overlap between **depression** and **FGID** is about **30% in primary care** settings and slightly **higher in tertiary care**.
Depression can impact the **number of functional GI s**ymptoms.
Comorbid depression has been linked to **poor outcomes, high health care utilization and cost, functional impairment, poor quality of life**.
Suicidal ideation is present in between 15% and 38% of IBS pts. linked to hopelessness associated with symptom severity, interference with life, and inadequacy of treatment.



Systematic review with meta-analysis: the prevalence of anxiety and depression in patients with irritable bowel syndrome

Mohammad Zamani[1,2] | Shaghayegh Alizadeh-Tabari[1] | Vahid Zamani[3]

Aliment Pharmacol Ther. 2019;50:132–143.

(73 studies).

Prevalence rates of **anxiety** symptoms and disorders in IBS patients were 39.1% and 23%, respectively
Prevalence of **depressive** symptoms and disorders in IBS patients was 28.8% and 23.3%, respectively

A higher prevalence of anxiety and depressive symptoms in **female** individuals than in male individuals.

IBS patients with high levels of **anxiety** were mostly those with **IBS-C and IBS-D**, while **depression** was associated only to **IBS-D.**

IBS clinical management in Italy: The AIGO survey☆

Marco Soncini[a], Cristina Stasi[b,*], Paolo Usai Satta[c], Giuseppe Milazzo[d], Margherita Bianco[e], Gioacchino Leandro[e], Luigi Maria Montalbano[f], Nicola Muscatiello[g], Fabio Monica[h], Francesca Galeazzi[i], Massimo Bellini[j], on behalf of the AIGO[1]

Digestive and Liver Disease 51 (2019) 782–789

HADS and SF according to gender

	Sex		
	Female (N = 493)	Male (N = 184)	p
Physical Component Summary — PSC-12 (M ± SD)	43.9 ± 9.1	45.2 ± 8.1	0.12[b]
Mental Component Summary — MCS-12 (M ± SD)	39.0 ± 11.0	41.7 ± 10.1	0.005[b]
HADS — anxiety (%)			0.007[a]
0–7 (Normal)	172⁻ (34.9)	86⁺ (46.7)	
8–10 (Borderline)	130 (26.4)	48 (26.1)	
≥11 (Pathological)	191⁺ (38.7)	50⁻ (27.2)	
HADS — depression (%)			0.013[a]
0–7 (Normal)	288⁻ (58.4)	124⁺ (67.4)	
8–10 (Borderline)	122 (24.7)	45 (24.5)	
≥11 (Pathological)	83⁺ (16.8)	15⁻ (8.2)	
Requested diagnostic test (%)			0.14[a]
No	66 (13.4)	33 (17.9)	
Yes	427 (86.6)	151 (82.1)	
Suggested therapies (%)			0.49[a]
No	31 (6.3)	9 (4.9)	
Yes	462 (93.7)	175 (95.1)	

Anxious pathological state in >1/3 of the pts.;
Depressive pathological state in 14.5% of pts.

Both anxiety (38.7%) and depression (16.8%) levels higher in **females**

The **mental** component of **SF 12** was lower in females

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HADS and SF according to severity of IBS symptoms

	IBS-SSS				p
	Normal N (%)	Mild N (%)	Moderate N (%)	Severe N (%)	
HADS — anxiety (%)					<0.001[a]
0–7 (Normal)	4 (100)	50⁺ (58.8)	162⁺ (49.2)	42⁻ (16.2)	
8–10 (Borderline)	0	24 (28.1)	95 (28.9)	59 (22.8)	
≥11 (Pathological)	0	11⁻ (12.9)	72⁻ (21.9)	158⁺ (61)	
HADS — depression (%)					<0.001[a]
0–7 (Normal)	4 (100)	53 (62.4)	240⁺ (72.9)	115⁻ (44.4)	
8–10 (Borderline)	0	27 (31.8)	64⁻ (19.5)	76 (29.3)	
≥11 (Pathological)	0	5 (5.9)	25⁻ (7.6)	68⁺ (26.3)	
Requested diagnostic test (%)					0.16[a]
No	0	19 (22.4)	45 (13.7)	35 (13.5)	
Yes	4 (100)	66 (77.6)	284 (86.3)	224 (86.5)	
Suggested therapies (%)					0.13[a]
No	0	9 (10.6)	21 (6.4)	10 (3.9)	
Yes	4 (100)	76 (89.4)	308 (93.6)	249 (96.1)	
Sex (%)					<0.001[a]
Female	2 (50)	52 (61.2)	228 (69.3)	211 (81.5)	
Male	2 (50)	33 (38.8)	101 (30.7)	48 (18.5)	
Physical Component Summary — PSC-12 (M ± SD)	53.6 ± 2.3	50.0 ± 6.9	46.3 ± 7.8	39.5 ± 8.6	<0.001[c]
Mental Component Summary — MCS-12 (M ± SD)	48.7 ± 6.1	44.5 ± 9.8	42.7 ± 9.4	34.2 ± 10.5	<0.001[c]
Age (M ± SD)	52.5 ± 4.7	45.3 ± 16.2	44.0 ± 15.3	41.0 ± 14.9	0.03[c]

⁺/⁻ Observed frequencies greater (+) than or less (–) than chance (adjusted residual analysis).

-**HADS**, request for diagnostic tests and therapy prescription increased with symptom severity.

-SF 12, both physical and mental components, decreased with increase in IBS-SSS.

Evidence that independent gut-to-brain and brain-to-gut pathways operate in the irritable bowel syndrome and functional dyspepsia: a 1-year population-based prospective study

N. A. Koloski*, M. Jones† & N. J. Talley*

Aliment Pharmacol Ther 2016; **44**: 592–600

2885 Australian adults

In patients with FGID and mood disturbances, the gut symptoms precede mood disorder in **2/3** of cases.

A third of patients develop mood disorders before the onset of gut symptoms.

Mood and Anxiety Disorders Precede Development of Functional Gastrointestinal Disorders in Patients but Not in the Population

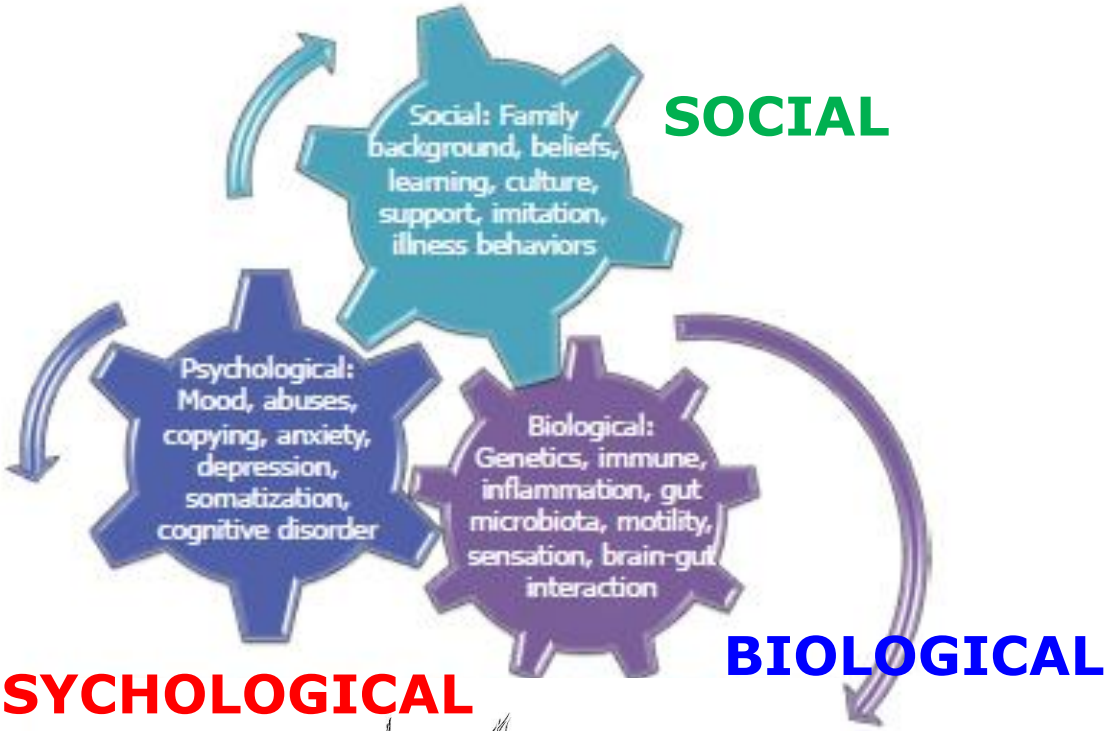
Michael P. Jones,[*] Jan Tack,[‡] Lukas Van Oudenhove,[‡,§] Marjorie M. Walker,[‖] Gerald Holtmann,[¶] Natasha A. Koloski,[‖,¶] and Nicholas J. Talley[‖]

Clinical Gastroenterology and Hepatology 2017;15:1014–1020

Among the 4966 health care seekers, 3279 patients were diagnosed with a **mood or anxiety disorder before** an FGID (ratio of **2:1**).

Among patients, the **mood or anxiety disorder** was on average diagnosed > **3 years before the FGID.**

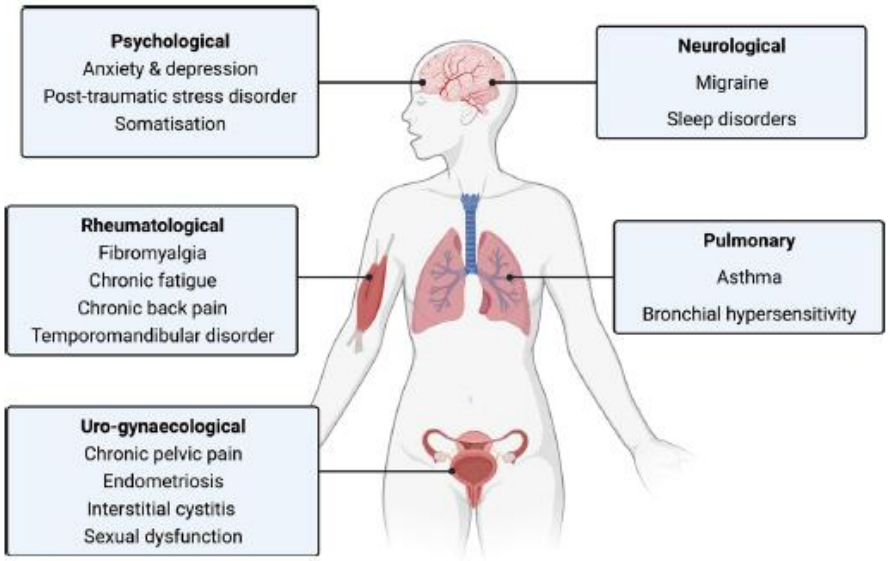
The **biopsychosocial model** is not only confined to the FGIDs but also adopted in many pain related disorders such as migraine, tension headache, chronic fatigue syndrome, and fibromyalgia. A concept of central sensitivity syndromes (dysregulated nociception) is proposed to unite these comorbidities that share the same biopsychosocial dysfunction ***(Chang FY, 2014)***



Common extraintestinal comorbidities of FGID

SOMATIZATION (2/3 of FGID pts.)

(Shiha G, 2021)



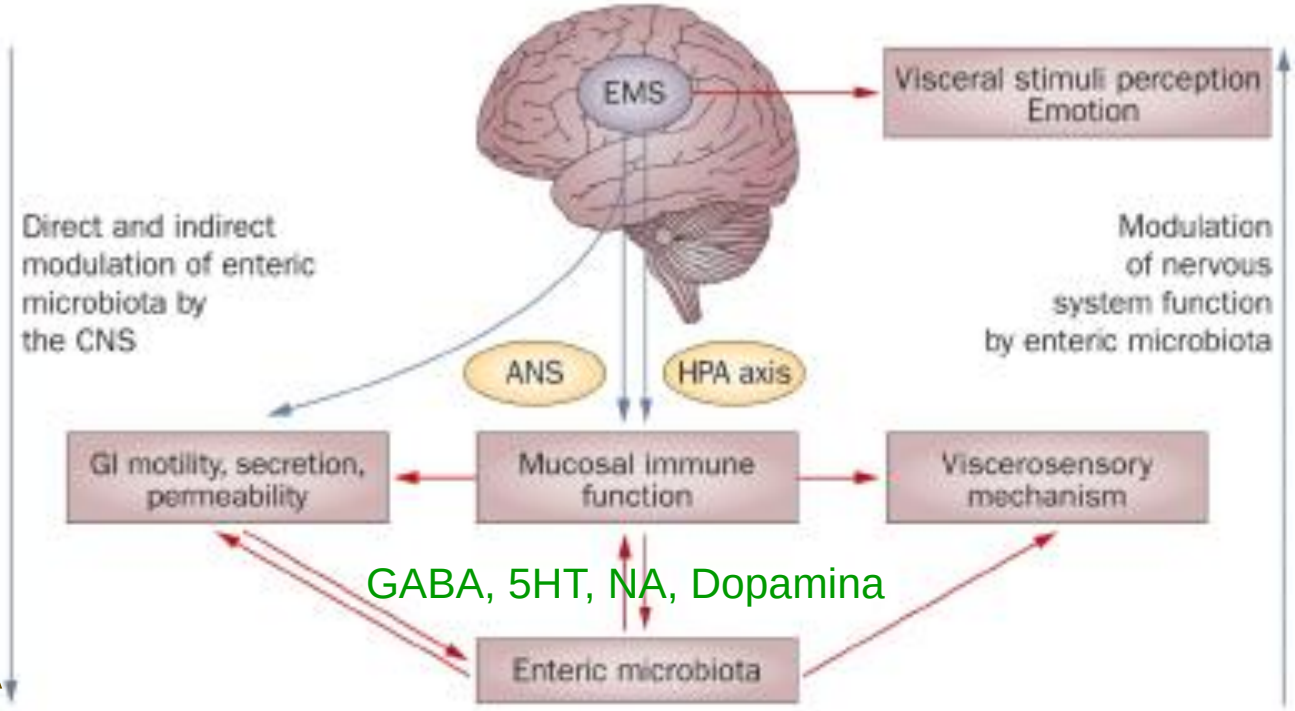
(Van Oudenhove L, 2016)

Somatization associated with
-increased frequency and **severity** of abdominal **pain**,
-reduced **productivity,**
-increased **healthcare utilisation (**inappropriate **investigations**, excess **medication** use and unnecessary **surgical** interventions) and **costs**
-increased psychological distress, patient **dissatisfaction**

BRAIN

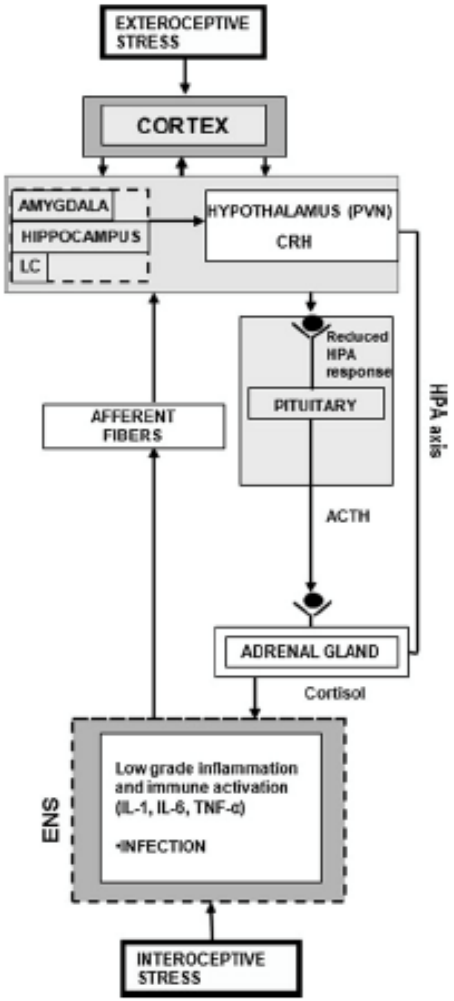
GUT

MICROBIOTA



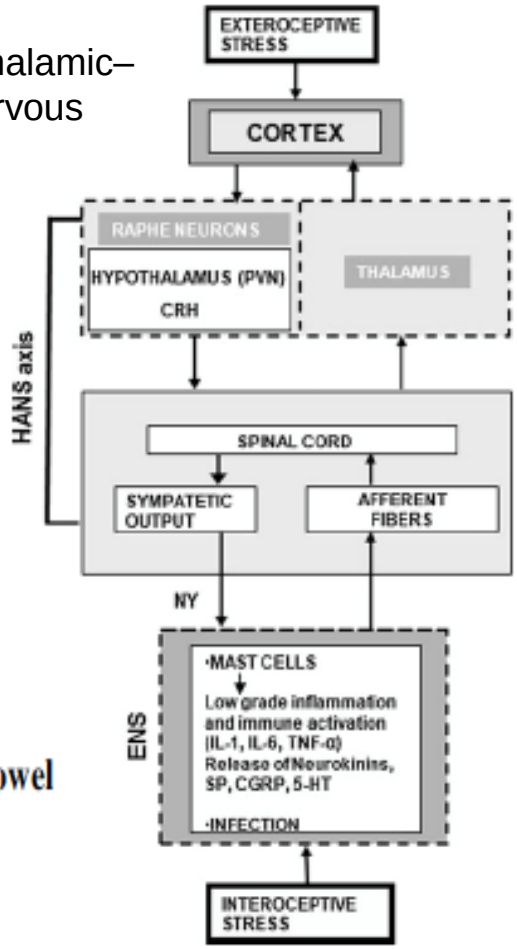
Bidirectional interactions between brain and enteric microbes might have an important role in modulating gut function and may be involved in the modulation of emotions, pain perception and general well-being.

FGID symptoms may be caused either by alterations in the **CNS** (top-down model), or in the **periphery** (bottom-up model), or in a **combination** of both. The brain–gut axis may be stimulated by various stressors either directed to the CNS (exteroceptive stress) or to the gut (interoceptive stress).



HPA: hypothalamic–pituitary–adrenal axis

HANS: hypothalamic–autonomic nervous system axis



Altered neuro-endocrine–immune pathways in the irritable bowel syndrome: the top-down and the bottom-up model

Cristina Stasi · Massimo Rosselli · Massimo Bellini · Giacomo Laffi · Stefano Milani

J Gastroenterol
DOI 10.1007/s00535-012-0627-7

Under **normal** physiological conditions, most of **interoceptive** gut brain **signals** are **not consciously perceived** because visceral afferent input is processed and continuously modulated by cognitive and affective circuits at the level of the **brain** and through **descending modulatory pathways.**

Van Oudenhove L, 2016

Altered visceral sensation in **IBS** is characterised by **central abnormalities** in sensory, emotional arousal, and prefrontal **cortical regions** of the brain.

Alterations in the **descending pathways modulating sensation** and peripheral mechanisms are also involved in the pathogenesis of visceral pain allowing physiological (non-noxious) stimuli to be perceived as painful or unpleasant (**allodynia / visceral hypersensitivity**)

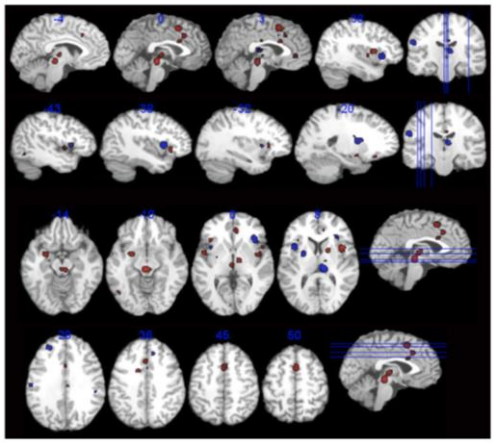
(Ford A, 2019)

GASTROENTEROLOGY 2011;140:91–100

Quantitative Meta-analysis Identifies Brain Regions Activated During Rectal Distension in Irritable Bowel Syndrome

KIRSTEN TILLISCH, EMERAN A. MAYER, and JENNIFER S. LABUS

Center for Neurobiology of Stress, Departments of Medicine, Physiology and Biobehavioral Sciences, David Geffen School of Medicine, University of California Los Angeles, Los Angeles, California



Neuroimaging studies: **changes in specific brain regions** in patients with IBS, involved in the processing of emotions, cognition, memory and autonomic functioning ***(Weaver KR, 2016)***

Patients with IBS have greater engagement of **regions involved in emotional arousal** network.

Measures of regional cerebral blood flow during rectal distention have shown that IBS patients have **greater activation** of the anterior cingulate cortex, amygdala and dorsomedial frontal cortex, in contrast to patients with ulcerative colitis and controls ***Mayer EA et al., Pain, 2005***

The antidepressant **amitriptyline** has been shown to **reduce rectal pain** and this has been **correlated to activation** of the right prefrontal cortex, right insula and perigenual anterior cingulate cortex. ***Morgan V et al., Gut, 2005***

ACG Clinical Guideline: Management of Irritable Bowel Syndrome *Am J Gastroenterol 2021;116:17–44.*

We recommend that TCAs be used to treat global symptoms of IBS.
Strong recommendation; moderate quality of evidence.

12 RCTs: IBS pts. randomized to a TCA were more likely to note improvement in **global IBS symptoms** compared with those randomized to placebo.

Of patients who received active therapy, 42.7% did not improve compared with 63.8% of those randomized to placebo who did not improve.

The **NNT** with TCAs was **4.5**

Patients should be started on a low dose (e.g., 10-mg amitriptyline or 10 mg of desipramine) with gradual dose titration upward to achieve therapeutic relief of symptoms while minimizing side effects

ACG Clinical Guideline: Management of Irritable Bowel Syndrome *Am J Gastroenterol 2021;116:17–44.*

> We suggest that gut-directed psychotherapies be used to treat global IBS symptoms.
>
> Conditional recommendations; very low quality of evidence.

Gut Directed Psycotherapies (GDPs) **in conjunction** with other IBS therapies for patients who are emotionally stable but who exhibit cognitive-affective drivers of IBS symptoms because

-low risk when used by **qualified health professionals**

-long-term benefits of these therapies even after they are discontinued;

GDPs are independent from IBS subtype

NNT collectively remains 4 when the validated IBS-SSS is used as a primary outcome measure

British Society of Gastroenterology guidelines on the management of irritable bowel syndrome

Gut 2021;**0**:1–27. doi:10.1136/gutjnl-2021-324598

Tricyclic antidepressants are an effective **second-line** drug for **global symptoms and abdominal pain** in IBS.
They can be initiated in primary or secondary care, but **careful explanation** as to the rationale for their use is required, and patients should be counselled about their side-effect profile. They should be commenced at a low dose (eg, 10 mg amitriptyline once a day) and titrated slowly to a maximum of 30–50 mg once a day
(recommendation: strong, quality of evidence: moderate).

Selective serotonin reuptake inhibitors may be an effective **second-line** drug for **global symptoms** in IBS. They can be initiated in primary or secondary care, but **careful explanation** as to the rationale for their use is required, and patients should be counselled about their side-effect profile ***(recommendation: weak, quality of evidence: low).***

British Society of Gastroenterology guidelines on the management of irritable bowel syndrome
Gut 2021;**0**:1–27. doi:10.1136/gutjnl-2021-324598

Psychological therapies

-IBS-specific **cognitive behavioural therapy** may be an efficacious treatment for global symptoms in IBS
(recommendation: strong, quality of evidence: low).

-Gut-directed **hypnotherapy** may be an efficacious treatment for global symptoms in IBS
(recommendation: strong, quality of evidence: low).

-**Psychological therapies** should be considered when symptoms have not improved after 12 months of drug treatment.
Referral can be made at an **earlier** stage, **if accessible locally**, and based **on patient preference**
(recommendation: strong, quality of evidence: low).

Psychological/psychiatric interventions: depending on the availability of appropriate resources and expertise

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Digestive and Liver Disease 51 (2019) 782–789

Therapies suggested by gastroenterologists in the different IBS subgroups.

	IBS IBS-C (N = 294)	IBS-D (N = 146)	IBS-M (N = 237)	p
None	16 (5.4)	6 (4.1)	17 (7.2)	ns
Life style and dietary suggestions	210 (71.4)	107 (73.3)	162 (68.4)	ns
Probiotics	125^{-} (42.5)	86^{+} (58.9)	129 (54.4)	<0.01
Fiber supplements	69^{+} (23.5)	9^{-} (6.2)	32 (13.5)	<0.001
Antispasmodics	13^{-} (4.4)	15 (10.3)	27^{+} (11.4)	<0.01
Stimulant laxatives	4 (1.4)	1 (0.7)	0	ns
Macrogol	146^{+} (49.7)	6^{-} (4.1)	31^{-} (13.1)	<0.001
Lactulose/lactitole	7 (2.4)	1 (0.7)	2 (0.8)	ns
Saline laxatives	2 (0.7)	1 (0.7)	2 (0.8)	ns
Enemas/suppositories/micro-enemas	12^{+} (4.1)	1 (0.7)	2 (0.8)	<0.05
Prucalopride	9^{+} (3.1)	0	0^{-}	<0.05
Linaclotide	25^{+} (8.5)	1^{-} (0.7)	5^{-} (2.1)	<0.001
Rifaximine	6^{-} (2.0)	12^{+} (8.2)	13 (5.5)	0.01
Mesalamine	9 (3.1)	6 (4.1)	3 (1.3)	ns
Herbal remedies	6 (2.0)	4 (2.7)	9 (3.8)	ns
Psychotherapy	44 (15.0)	19 (13.0)	29 (12.2)	ns
Antidepressant drugs (TCA/SSRI)	0 (0.0)	0 (0.0)	1 (0.4)	ns
Loperamide	0 (0.0)	18 (12.3)	7 (2.9)	<0.001
Other	41 (13.9)	14(9.6)	28 (11.8)	ns

$^{+/-}$Observed frequencies greater (+) than or less (–) than chance (adjusted residual analysis).

Should IBS patients be assessed for psychological comorbidities?

We recommend FOR psychological comorbidities assessment in IBS patients.

Consensus recommendation; unable to assess using GRADE methodology.

Who, When and Why?

Irritable bowel syndrome in adults in primary care: summary of updated NICE guidance

BMJ 2015;350:h701

Cheryl Hookway *technical analyst*[1], Sara Buckner *technical analyst*[2], Paul Crosland *health economist*[2], Damien Longson *consultant liaison psychiatrist*[3]

Consider referral for psychological interventions (cognitive behavioural therapy (CBT), hypnotherapy, or psychological therapy (or a combination)) in people who do **not respond to drug treatments after 12 months** and who develop a continuing symptom profile (described as **refractory IBS**).


NASCONO GLI JUVENTINI NEGAZIONISTI
VERI INTERISTI
MAI IN SERIE B
VIA CALABRIA
LA CHAMPIONS NON ESISTE


TIEDEMANN

GUIDELINES AND FLAG

⚐ Cons

Question	*An*
1. Question for anxiety: In the last week, have you felt tense or wound up?	○ ○ ○ ○
2. Question for depression: In the last week, have you felt downhearted and low?	○ ○ ○ ○
3. Question for suicidal ideation: Have you recently felt so low that you felt like hurting or killing yourself?	○ ○ ○

GUIDELINES AND FLAGS FO

⚐ Consider i

Question	*Answer*
4. Question for sexual abuse: Have you ever been emotionally, physically, or sexually victimized at any time during your life?	○ *Yes* ⚐ ○ *Never*
5. Question for physical abuse (by partner): Have you ever been afraid for your safety in your intimate relationships?	○ *Yes* ⚐ ○ *Never*
6. Question for pain severity: During the last *four* weeks, how much bodily pain have you had?	○ *Very sev* ○ *Severe* ⚐ ○ *Moderat* ○ *Mild* ○ *None*

GUIDELINES AND FLAGS FOR REFERRING TO A MENTAL HEALTH PROVIDER

⚐ Consider involvement ⚑ Involve quickly

Question	*Answer*	*Scoring*
7. Question for somatic symptoms and related anxiety: For the last six months or longer, have you worried about physical symptoms that you believe are serious?	○ *Yes* ⚐ ○ *No*	**Question Origin** If the response is "***Yes,***" then the clinician should ask: "Is this currently causing you distress in your life?" **and** "Would you like to see someone to discuss this in more detail?" If the patient agrees that he/she is very distressed and would like to see someone, then the clinician should refer to a mental health professional (provided the patient agrees).
8. Question for impairment: During the last four weeks, how much does pain (or other symptoms) interfere with your normal activities (including work both outside the home and housework)?	○ ***Extremely*** ⚐ ○ ***Quite a bit*** ⚐ ○ *Moderately* ○ *A little bit* ○ *Not at all*	**Question Origin** Patients answering ***"Quite a bit"*** or ***"Extremely"*** to this question (question 8 of SF-36) represent 26% of patients with functional gastrointestinal disorders whose physical component score is 2 standard deviations below the population norm.[1,2]
9. Question for drug/alcohol abuse: In the past year, how often have you used alcohol (for men, 5+ drinks/day, for women, 4+ drinks/day)/tobacco products/prescription drugs for nonmedical reasons/and/or illegal drugs?	○ ***Daily or Almost Daily*** ⚑ ○ ***Weekly*** ⚐ ○ *Monthly* ○ *Once or Twice* ○ *Never*	**Question Origin** This sample question is taken from the National Institute for Drug Abuse Drug Screening Tool (http://www.drugabuse.gov/nmassist/). **Rationale for Red Flag Scoring** Patients who answer ***"Daily or Almost Daily"*** to any of these questions are likely to have a serious drug or alcohol addiction. The clinician should assess further and determine if a referral to specialty treatment is warranted.

Hospital Anxiety and Depression Scale (HADS)

(*Zigmond and Snaith, 1983)*

The items on the questionnaire that relate to **anxiety** are
-I feel tense or wound up
-I get a sort of frightened feeling as if something bad is about to happen
-Worrying thoughts go through my mind
-I can sit at ease and f
-I get a sort of frighten
-I feel restless and hav
-I get sudden feelings

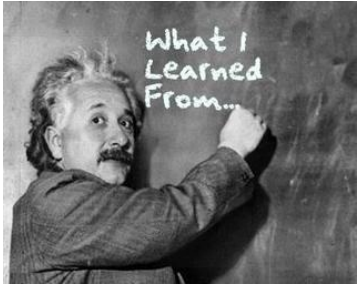
The items that relate t
-I still enjoy the things
-I can laugh and see th
-I feel cheerful
-I feel as if I am slowed down
-I have lost interest in my appearance
-I look forward with enjoyment to things
-I can enjoy a good book or radio or TV programme

Each item: 0-3; Cut off: 8/21

Anxiety (HADS-A): -specificity: 0.78 -sensitivity: 0.9.

Depression (HADS-D): -specificity: 0.79 -sensitivity of 0.83.

(Bjelland et al 2002)



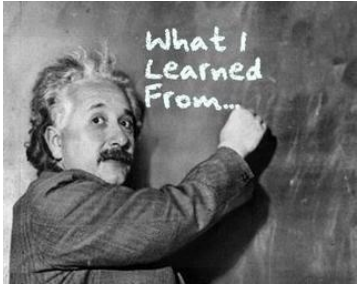
Take Home Messages (I)

Interplay is still a **complex matter** (chicken or egg?)

PSY comorbidities should be systematically **checked** and **treated** in FGID patients

PSY therapies (TCA/SSRI, cognitive behavioural therapy, gut-directed hypnotherapy, etc.) can be **effective** interventions in **FGID symptoms**

In FGID patients with high psychological burden, **early PSY interventions** may alter disease course and break the vicious cycle of **unnecessary investigations, interventions, and excess healthcare utilisation**.



Take Home Messages (II)

Psychiatrist/psychologist employment is still hindered by a **lack of trained therapists and available services**.

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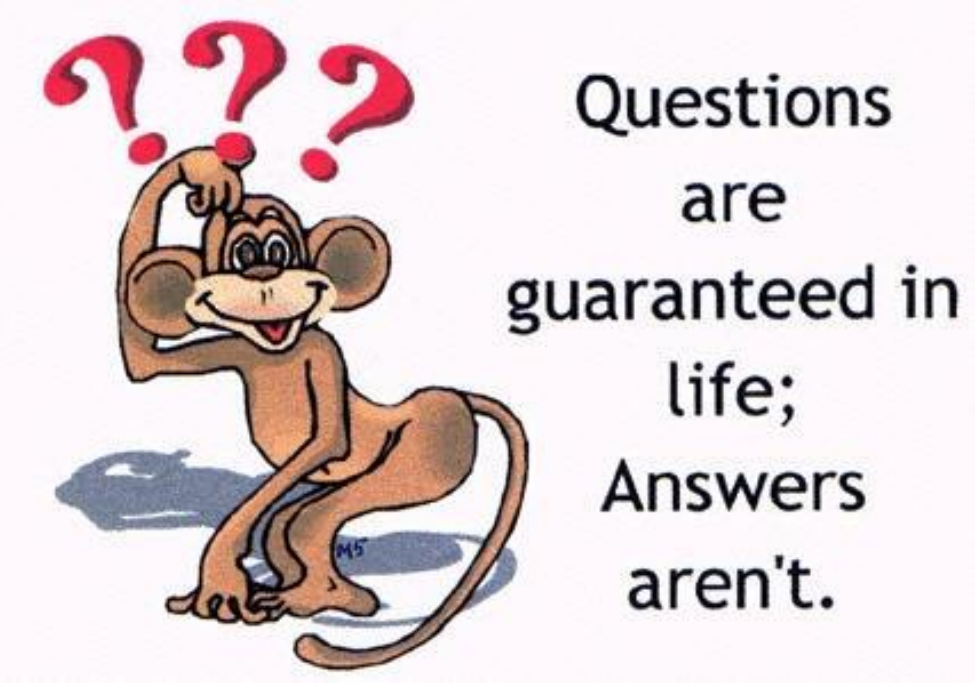
Treatment of FGID symptoms in the patients with anxiety and depression can **improve their PSY** symptoms.

A **multidisciplinary** management of FGID patients (mainly in tertiary care) is mandatory


Questions
are
guaranteed in
life;
Answers
aren't.