

# PREFACE

“What matters in chronic disorders is the patients’ suffering,  
not the disease entity”

“La nature m’enseigne aussi par ces sentiments de douleur,  
de faim, de soif, etc. que ne suis pas seulement logé dans mon corps,  
ainsi qu’un pilote en son navire,  
mais outre cela que je lui suis conjoint très-étroitement  
et tellement confondu et mêlé  
que je compose comme un seul tout avec lui”  
*Réné Descartes. Méditations Métaphysiques. 1641*

With economic, scientific, and technological developments, the populations of industrialized countries have experienced a dramatic decrease both in the death rate and in acute infectious diseases as well as an increase in chronic morbid conditions that parallel the prolonged life expectancy and that negatively affect the health status and quality of life. Hence, the main challenge for the health care system of these industrialized countries is to be able to deal with the impact of the chronic diseases as far as concerns high prevalence, elevated degree of individual suffering, high demands on the medical profession, inadequacy of therapeutic means, and elevated costs.

Chronic Gastrointestinal (GI) disorders represent a large proportion of all chronic diseases, with which they share several common features. Not unlike other chronic diseases, the prevalence of Chronic GI Disorders (CGID) is increasing with the increase in life expectancy and improved therapeutic means to cure life-threatening complications. In addition, they present aspects peculiar to the GI tract that, besides being the

nutritional organ, is the largest surface of the body exposed to the environment, the largest immune organ and second only to the brain in terms of innervation. It is not surprising that chronic GI disorders can originate from several different conditions: genetical, immunological, nutritional, neuromuscular. The environment, physical and social, as well as psychological conditions play a determinant role in the onset of chronic GI disorders.

Not only are chronic GI disorders numerous and highly prevalent, but the toll paid in terms of individual suffering is considerable although not self-evident. In CGID, the degree of suffering and the disease manifestations themselves are not proportional to the pathophysiologic modifications/impairments, clinical expression and treatment outcome, but are, rather, the end result of the interference of the GI disorder on eating and defaecatory behaviour and their interactions with the psychosocial factors. As far as concerns the latter, an abnormal patient's illness behaviour, sustained by the chronic state of suffering itself, and/or the concomitance of stressful events should be taken into consideration. In this respect, a great deal of attention has been given to the close relationship between physical and/or sexual victimization and health care seeking attitude, chronicization of the disorders, low health status, and poor response to treatment. On account of all these considerations, the impact of CGID on the health status cannot be well assessed by listing symptoms, signs or pathological findings, but rather from assessing the Quality of Life, that takes into consideration several domains of well-being.

The management of patients with chronic diseases differs markedly from that of patients with acute diseases not only in the diagnostic approach and the treatment, but also in terms of outcome. In acute conditions, the widely applied biomedical model centered on identification and removal of causative factors in a condition expected, both by the patient and the physician, to be reversible is usually satisfactory whilst, in chronic conditions, the causative factors cannot always be identified and/or the therapeutic armamentarium is unable to resolve the condition. Consequently, a linear relationship between the identification of causative factors and their resolution is often hairline or totally lacking.

The widely applied, mainly disease-centered, biomedical model is, to a large extent, unsatisfactory in chronic conditions requiring a different medical approach which should be centered on the patient, taking into consideration, together with the disease entity, his/her long-term suffering or disability as well as his/her expectations as far as concerns the persistent state of illness and to the everyday social, physical and emotional aspects.

Until now, initial medical training takes place in teaching hospitals where chronic conditions are not dealt with, except for acute remissions and complications and where the disease-centered biomedical model of the acute condition is learnt as the basic, and often the only prototypic, medical approach to be, from then on, applied, by the practising physician, even in non-acute, non-hospitalized patients. Since 80% of the conditions outside the hospital are chronic, it is self-evident that a disease-centered biomedically based training cannot adequately match the need of the population health status.

Traditional biomedically-centered education and technological diagnostic and therapeutical advancements, mainly directed towards well-defined pathological and functional modifications, have greatly influenced the approach to patients with CGID which differs according to the entity of the disease. The approach to diseases with known structural or biochemical abnormalities is standardized and directed mainly to specific aspects of the pathological condition, such as diagnosis, complications, treatment of the aetiologic and/or pathophysiologic factors, focusing less on the patients' suffering, which is the result of the interactions of the physical alterations with the psychological and behavioural as well as the social/environmental conditions.

Once an organic disease has been excluded, the approach to disturbances with no known structural or biochemical abnormalities, is not standardized and the treatment is often selected in keeping with the physician's specialty rather than with the patients' needs. In these functional conditions, there is also a tendency on the part of some physicians to attempt symptomatic treatment and to minimize issues of suffering "due to stress and/or psychological causes", or, on the contrary,

to focus on the psychological aspects, ignoring the physical dysfunctions. In addition, there is a trend to overlook the fact that organic and functional disorders are frequently associated and each of them may give rise to the other and that CGID may cause such disability as to markedly interfere with everyday life, regardless of the disease entity.

In the attempt to develop awareness on patients presenting with chronic suffering with pain and/or dysfunctions originating from the gastrointestinal tract, ANEMGI (Associazione per la NeUro-Gastroenterologia e la Motilità Gastrointestinale) promoted an interdisciplinary symposium in Baveno, Italy, 10-13 June 1998.

This volume is the outcome of data presented and discussed at the Baveno Symposium.

The contents highlight the basic approach to chronic GI disorders, often referring to the patient-centered biopsychosocial model and the close relationships between functional, organic and psychological disorders.

Several chapters deal with specific disease entity, and in many an effort is clearly made to offer an approach to the chronic conditions which would take into consideration the different life and health domains of the patient.

This volume has been compiled with the collaboration of renowned experts in the field and I am confident that this text will contribute to reinforcing and advancing our knowledge on Chronic Gastrointestinal disorders.

*Enrico Corazziari*