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Interpretation of Signs and Symptoms in Different Age Periods

PEDIATRIC DIAGNOSIS

SECOND EDITION

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PREFACE TO THE SECOND EDITION

THE SECOND EDITION of this book has involved much rewriting along with extensive additions to the manuscript. This represents an attempt to keep the book current and to increase its usefulness.

This is not a textbook of pediatrics in the ordinary sense of presenting an encyclopedic coverage of the subject. Rather, it is intended to complement such works and to represent another way of looking at the patient through symptoms, signs and age periods. Physical diagnosis receives special emphasis because it is basic to a sound diagnostic approach. Also, *pediatric* physical diagnosis tends to be neglected in general works on the subject.

Attention is given both to the traditional concern of pediatrics with physical disease and to its newer interests in the psychosocial aspects of childhood. The new chapters on dysphagia, delirium, chest pain, irritability, vertigo, fainting and headache reflect the combined diagnostic consideration given to both physical and psychologic considerations. The section on medical history has been expanded to include additional comments on the important skill of interviewing. Inclusion of the references in the body of the text has received general approval and is continued in this edition. An effort has been made to include chiefly the more recent references which the reader may wish to consult.

We hope that appropriate use of this book will lead to increased diagnostic skill through emphasis on thoroughness of history, scrupulous physical examination and reasonableness in use of laboratory procedures, and thus help the physician to heed the time-honored aphorism—"diagnosis before treatment."

We wish to acknowledge the stimulation and enlightenment provided by many colleagues, especially Drs. Milton J. E. Senn, Sally A. Provence and Albert J. Solnit at Yale; Lyman T. Meiks, William E. Segar, Paul R. Lurie, Dwain N. Walcher, Arthur L. Drew and James E. Simmons at Indiana; and William Bergstom, Bettye Caldwell, Evelyn Eddy, Lytt I. Gardner, Sterling Garrard, Leonard Hersher, George Husson, Earle Lipton, A. J. Schneider and Paul Wehrle at Syracuse.

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Section 1

INTRODUCTION

THE PEDIATRIC HISTORY

THE PEDIATRIC HISTORY

Conventional medical history-taking has consisted largely in a patient's* telling the story of his illness briefly followed by his answering a set of routine questions commonly referred to as an "inventory." Though this approach helps the physician to provide appropriate medical care, fuller realization of the physician's potentialities to help the patient is dependent upon a broader view of history-taking. Apart from obtaining the data necessary for the care of illness in children, the process of eliciting the pediatric history may have an important psychotherapeutic function. This would seem to be especially important today with the physician being increasingly consulted because of problems that have psychologic implications. Flexible and imaginative history-taking develops when the experienced practitioner modifies the conventional procedure, thereby being enabled to acquire better understanding of the patient within a limited time while simultaneously establishing rapport and engaging in a therapeutic relation. A prerequisite for this approach is the physician's enjoyment of interpersonal relations, a basic curiosity about them, a sensitivity to the patient's feelings and an ability to fashion the interview to the situation at hand. The medical history too frequently becomes a routine, almost automatic procedure rather than an individualized session in which the physician attempts to understand the patient and the patient's problems and in which the patient experiences the feeling that he is receiving personal, expert attention.

No two people can be interviewed in exactly the same way. No two physicians who interview skillfully do it the same way. No two patients with the same disorder present the same history. Discussions on the technique of interviewing may provide certain fundamental principles, but they cannot depict exactly how this is done, since this is dependent upon the personality of the interviewer and on the nature of his past experiences. Skill in interviewing is achieved through thoughtful experience with many patients with varied problems and backgrounds.

The physician is more effective in helping the patient when he integrates both organic and psychologic possibilities without considering one rather than the other. The etiology of abdominal pain, anorexia, vomiting, headache, diarrhea and other symptoms may have an organic or psychologic basis, or both. Though the patient's presenting symptoms may have an organic basis, there are often secondary psychologic problems. It is important that the history of organic factors be a competent and skillful one; this demonstration of diagnostic thoroughness and skill is, in itself, supportive psychologically.

The topic headings usually considered in medical history-taking, e.g. "present illness," "past medical history," "family history," will not be dealt with at length in this chapter. This material is well known and need not be repeated here. What does warrant repetition is the diagnostic importance of detail in history-taking—an exact description of the symptoms or signs reported, their chronology, the circumstances surrounding their occurrence, and the like. Diagnosis is a matter of having in mind the various possible explanations for presenting signs and symptoms. The medical history serves as an important diagnostic tool to help rule in or exclude these possibilities.

The length and direction of the history depend upon the circumstances surrounding each case. In emergency situations

* The term *patient* will be used to refer either to the child or to the parents as appropriate in the text.

history-taking is, of course, limited to essentials for immediate diagnosis and therapy. When seeing children who are ill, it is often inappropriate to probe beyond the immediately pertinent history.

The chief complaint initially given by a parent may not be the most important reason for bringing the child to the physician. The real problem may not become apparent to either the parent or the physician until later. In other situations the parent may not feel free to disclose her primary reason for coming until she has decided whether the physician is receptive and understanding. In listening to the chief complaint and the narrative, it might be well to ask oneself, "Is this really why they came to see me?" Particularly in the case of psychologic complaints one learns, understandably, to be skeptical of the history as first given.

It must be remembered, nevertheless, that the chief complaint reflects the problem with which the *patient* is most concerned or feels most comfortable in presenting. Even though the physician, because of the background, can instantly recognize or suspect that this is not the *real* problem, the central focus of the consultation should remain the chief complaint. The discussion should always be brought back to this topic before the interview is brought to a close. If this is not done, the parent may be rendered unduly anxious by the physician's interest in more sensitive areas and, consequently, fail to return. As rapport develops in subsequent visits, these problems may be dealt with more fully.

The physician may be able to gain some idea of what can be accomplished and the direction of management to be undertaken in a given situation by asking the parent to express what she thinks the cause of the child's problem might be. It is helpful to know what the parent or child means when they use terms such as "mental retardation," "mental illness," "spoiled," "dizzy," "rheumatic fever." It may also be of interest to know what the parents have been doing about the problem, why they come in now, whose idea it was to come, and what they expect the physician to be able to do. To a certain extent, knowledge of what the parents expect permits the physician to present his medical evaluation in a meaningful way. The physician must determine what the patient really wants and whether he is ready to accept help. Obviously the patient's cultural, social, educational and intellectual background conditions his expectation of how the physician can help.

Rather than being forced to follow a prescribed form, it is important that the patient be encouraged to talk fully and frankly, to tell the story in his own words, to share his feelings and concerns; otherwise he may give the history according to what he thinks the physician is interested in hearing. This need not coincide with what the patient wants to talk about. Forms and outlines may be a convenient way for the beginning student to learn the information necessary for eliciting the history of a pathologic process. They have definite limitations, however, and may even become antitherapeutic and antidiagnostic. The order in which the patient presents problems may permit one to determine what importance he attaches to his problems, and to have an idea which problem is bothering him the most. Recurrent references, important omissions, association of ideas and events are of great diagnostic interest. The patient's first statement and that at the very end of the interview (when the interview is "over") are often of especial significance.

The patient's narrative may be interrupted by the physician at times to have the patient elaborate upon some detail, to help him go on with the history or to lead the discussion into more productive channels. Pertinent interruptions are not disturbing to the patient, but serve to show that the physician is listening carefully and that he is interested in obtaining an ac-

curate understanding of the problem. The interview situation can continue during the physical examination. Patients may talk more freely at this time than before. They may also recall facts that did not come to mind while the main body of the history was being elicited.

The pediatric history involves a triangular relation among physician, child and parents. Whether the physician interviews parents and child together or separately depends upon the specific situation. In many instances the physician may interview parents and child together and later interview them separately. In other cases he may first interview the parents and then arrange an appointment to see the child. This approach is particularly suitable when the patient is an adolescent. Although it is usually helpful to interview parents together and thus gain some impression of their interaction, separate interviews with each parent may be indicated in some cases. Generally children who are old enough to be verbal may profitably be interviewed separately by the physician if there is an emotional problem present. Interviewing of the family as a unit, including children above the age of eight years, may also have a place in pediatric care, especially with the growing interest in family-oriented diagnosis and treatment. When interviews are to extend over a period of several sessions, the physician may wish to utilize the help of a medical social worker, especially with parents, in elaboration of the history.

The manner in which children are interviewed varies considerably with their age. One introduces himself to the child and may explain what kind of physician he is. The friendliness of the physician helps put the child at ease. As Solnit has emphasized, establishment of a positive, guiding relation and encouragement of an identification of the child with the doctor are part of the deliberate therapeutic effort of the children's physician. In talking with a child the physician uses simple words, but the language is that which a child expects from an adult. Very young children are commonly "interviewed" for a few minutes by informal, casual games that the physician and the child enjoy as a way of getting to know each other. There are no set rules or ideas for this. With young children the interview may be facilitated if a few toys are available, e.g. ball, crayons and pad, picture books and a doll and bottle. The older child may be able to add a great deal of factual material to the history and will benefit from being encouraged to talk about himself.

Although some children talk more readily than others, getting them to talk generally presents no problem. Adolescents usually discuss their thoughts readily, although it may take some time before they bring up their most worrisome problems. When a child does not talk spontaneously, it will be necessary for the physician to be more directive.

The interview may start with a statement such as, "I'm Doctor Smith. I'm a doctor who is interested in helping children. I wonder if you would tell me why you came to see me (or why your parents brought you to see me)?" If the child denies knowing the reason for the referral, the physician might mention what the parents have indicated is the problem.

Topics that may be brought up in interviews with children include members of the family, school experiences, friendships, recreational interests, career aspirations, plans for a wife or husband, heroes, dreams, and things done for "fun." In order that the patient not feel especially different from others it may be well to preface some of the questions by a statement such as, "Most boys your age are concerned about ———. I imagine that you may be also." Other questions that may be appropriate include inquiry about things that make the child angry, sad, worried or happy and what he does under these circumstances. The time-honored question as to what three wishes the child would most

like to have fulfilled is often very informative of his emotional life.

The parent's or child's narrative may be supplemented by questions phrased to obtain certain specific items of information or to permit a more generalized discussion. For the latter purpose topic kinds of leading questions may be asked. Such questions permit more meaningful answers than those which can be answered by "Yes" or "No." One device which the physician may use to have the patient supply additional information is repetition, with a changed inflection, of a significant word or phrase from the patient's preceding statement. One may also ask, "Why do you say that?" when further elaboration is desired. Similarly, when interested in additional information, one may reply to a patient's question with the question, "Why do you ask?" or "How do *you* feel about it?" Questions that permit an evaluation of a patient include, "How are things going?" "How have you felt lately?" "How would you describe yourself (your usual mood) (your feelings)?" "How would others describe you?" "What are the attitudes of others toward you?" "How would you describe your father (mother, husband, wife, child)?" "Often our children remind us of someone. Whom does John remind you of?" "Would you tell me what has *really* been worrying you about your child?" When one is reviewing the prenatal period and early infancy, the question, "Did you have anyone help you during this time?" may provide some information on the mother's concept of her relation to others. A history of a postpartum depression may be important in understanding the genesis of some problems. When a physician has cause to believe that the symptoms attributed to a child are due to parental problems, a properly phrased question may bring out the underlying difficulty that the physician's experience has demonstrated likely to be pertinent. This *associative exploration* is useful, of course, in the diagnosis of both organic and psychosocial disorders. Thus, if a mother consults a physician because her child is "nervous," the question, "Who else in the family would you say is nervous?" may be productive of much significant information about the mother's or father's "nervousness." The terms "sensitive" or "blue" may be easier for the patient to talk about than "nervous" or "depressed." The physician is interested in many things such as presence of marital conflicts, health of the parents and other members of the family, recent deaths in the family, the father's and mother's employment and who lives in the house. Discretion and tact are indicated when inquiring about matters which the patient may be hesitant to discuss. The patient should not be encouraged to reveal more than he is currently prepared to talk about. The patient's defenses should be respected. It may be pointed out to the patient, however, that further interviews would be helpful in getting to know the child and family better.

Interviewers will differ in their attitude toward note-taking. In general, it is proper to jot down pertinent dates and names. Too vigorous note-taking, however, may suppress significant portions of the history, especially if the problem is a psychosocial one. In addition, it is difficult both to write and to observe the patient at the same time as the story unfolds. If adequate notes are not made during the interview, a summary should be written or dictated promptly after the session.

Every effort should be made to place the patient at ease. Privacy is, of course, essential. The conversation may begin with a discussion of some pleasant matter unrelated to the patient's chief problem and then proceed to the main purpose of the interview as soon as a relaxed and friendly relation has been established. Lewin has stated appropriately that "the patient comes to the doctor with an attitude that has a history." This attitude may condition the

success or failure of one's diagnostic and therapeutic efforts. The fact that most patients come to the physician with the "attitude" that they will be helped usually provides them some relief from anxiety, at least for the first visit.

There are a number of factors which permit patients to talk freely to their physician. Talk is facilitated if the physician is a warm, friendly, nonjudgmental, responsive and courteous person who sincerely wants to understand the problems of his patients. There is no one pattern by means of which these attitudes are transmitted to the patient. The alertness with which the physician follows what the patient is saying, his facial expression (nonverbal communication) and the tone of his voice are important in this regard. Optimally, the patient can sense that the physician knows how he feels. Secure in his relation with a physician in whom he has confidence and who appears unhurried and personally concerned, the patient is able to bring up and discuss problems and feelings that ordinarily might be embarrassing, e.g. marital conflicts, secret and inappropriate fears, much more easily than when the physician is austere, impersonal and only "professionally" interested. The patient may be helped in bringing up pertinent associations if the physician indicates his understanding by a statement such as, "These things are hard to talk about."

The physician is a person with status who is able to promote confidence; he has knowledge that gives relief, and an understanding of people without a need to moralize. It is therapeutic for the patient to ventilate feelings, to sort out thoughts, and to be encouraged and enabled to communicate fears and worries to a physician who is interested and listens *actively*. The physician's capacity to *listen* has a history conditioned by the whole background of his personal experience and professional training. The nature of his "receiving apparatus" determines what the physician gets out of the patient's story and whether he picks up not only what the patient says, but the undertones and overtones which are implied as well. The physician listens especially for recurrent references and important omissions. He is also interested in the affect that accompanies the interview, whether the patient demonstrates any anxiety about the problem, whether persons are described in terms of physical complaints and attributes or in terms of personality and feelings. He also knows that the questions, concerns or beliefs attributed by the patient to someone else are often those of the patient himself.

The physician sees many persons, both children and parents, who have a low self-esteem. Such patients may be especially helped by the skillful interviewer. The fact that a person with the status of a physician will listen to his story gives the patient status and a chance to increase his own self-respect. The patient must believe that the physician has respect for him as a person and accepts him with whatever feelings he possesses. This feeling of acceptance may permit an otherwise insecure person to function more effectively and perhaps to solve some of the problems which, heretofore, he had not been able to work through. The supporting relation between a skilled physician and his patient—this sharing of worries, feelings and puzzlements—promotes an understanding of the patient's problems and, as a result, leads to a diminution of anxiety. Apart from reassurance, when indicated, directed and sympathetic listening is often much more important therapeutically than what the physician has to say. And what the physician says is not as important as what the patient *thinks he said.* The physician should provide help at the level at which the patient is prepared to receive it (the capacity of the patient's "receiving apparatus"); this should not be in terms of the physician's idea of what is best in the long run, but rather in terms of what the *patient* needs currently.

It is important that the physician not play the role of a glib "advice-giver," especially when such advice is based on an incomplete and hurried estimate without sound understanding of the problem. One should also not promise too much therapeutically, since this tends to promote undesirable dependency. Also, glib reassurance may serve to minimize the problem sufficiently so that the patient feels no need to return for additional help.

Though it is important for the physician to have a great interest in other people as human beings, to have an awareness of their problems and to sense their attitudes and feelings, he should remain as objective as possible. Empathy with the patient who has difficulties is a basic quality of a good physician; identification may, however, not only interfere with the physician's perspective and effectiveness, but may also cause him much unnecessary personal distress. The problem must remain that of the patient; he is the one who must work it through, aided by the acceptance and understanding which he receives from the physician. Although patients often are aware of some aspects of the physician's family and pattern of living, it is well that he avoid intruding his personal life as an example or otherwise. He should also not be too intimate or overreactive; such familiarity decreases the effectiveness of the physician-patient relation, since the patient properly feels that the physician no longer is objective.

Adequate time should be permitted for the history, but the interview should be kept within limits that are fruitful and which correspond realistically to the demands of practice. The interval between interviews can be helpful in making the patient aware of new associations. At the end of the interview the patient can be asked to think about some of the things that have been discussed. It may also be suggested that other pertinent thoughts will probably come to mind before the next interview. He may also be encouraged to think of ways in which his problem might be helped.

Occasionally parents do not recognize the diagnostic importance of a thorough history, even when the history is confined to organic considerations. They seem to feel that by examining the child the physician can find "the answer"; they wonder why so much time is taken with questions and why the physician does not examine the child immediately. When one senses this attitude, the initial history should be brief with just enough information to permit one to do an intelligently directed physical examination. The history may be continued during this time. After completion of the physical examination the parent may then be ready to complete the details of the history.

The physician should be careful not to spend an undue amount of time with the patient unless a specific indication exists. The physician who does not set limits tends to depreciate the value of his time. This may interfere with the respect the patient has for him and may, as a consequence, reduce his effectiveness. An excessive amount of time spent with the patient may also promote dependency on the physician. The interview should end as it began with the patient comfortable rather than in an area characterized by much emotional tension. As mentioned previously, the discussion may be returned to the presenting complaint. This will increase the likelihood of the patient's returning for subsequent visits. The interview may be terminated by getting up, by walking to the door or by a statement such as, "Well, I guess that our time is up."

Occasionally, periods of silence occur during the patient's narrative. These intervals should not be hurriedly interrupted. The patient may be trying to remember some elusive detail or may be attempting to formulate in words some experiences which have been troublesome. If the pause is prolonged and the patient evidently is waiting for a further cue, the examiner