LEADING ARTICLE

Semeiology—a well established and challenging paediatric speciality

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"This week's mystery comes from seven-year-old Callum from Middlesex who, when walking a variable distance, develops an ache around the knees and down his calf of such severity that he has to stop, when it disappears immediately. He also used to wake at night complaining of 'pains in the leg' when younger. This has now improved. This is a most puzzling case, as the relationship to exercise is strongly suggestive of interruption of the blood supply or claudication, though this would not explain the nocturnal pain. Callum has been investigated from top to toe by paediatric specialists, who have been unable to reach a diagnosis. So he, and his mum, will be more than grateful if anyone out there has any suggestions."

(Dr James Le Fanu, Doctor's Diary, *Daily Telegraph*, 2 April 2002)

Children may experience many persistent life affecting symptoms, such as in the example reported above. The reaction of paediatricians to this story probably varies, ranging from those who would sympathise with Callum and his mother at the inability of the medical profession to diagnose and treat his troublesome symptoms to those who would speculate that their perpetuation is made more likely both by the number of paediatric specialists consulted and by his anecdote appearing in a national newspaper. Some might even argue that the case as described is prima facie abusive and that what Callum needs is protection from his mother. Before criticising it is worth remembering the advice¹ of a medical parent: "If your child is ill or you are worried, shout to the rooftops or guilt will walk with you as a constant friend." A friend?

Callum's clinical picture and its consequences are familiar to all general paediatricians, especially those working in tertiary centres. Paediatricians in organ based specialties receive plenty of referrals of children with, for example, renal, liver, and malignant disease. The stock in trade of a tertiary care generalist is children whose symptoms are unexplained and who, like Callum, may have done the rounds of specialists. The complaints are familiar enough: pain; dizziness; pins and needles; nausea and vomiting; fatigue; anorexia; abdominal distension and loose stools; frequency, urgency, and dysuria; irritability; funny turns; and many others, individually or severally. They may start during the winter months and one suspects that infective triggers play a part. (Is it possible that infections might cast longer symptomatic shadows than the medical profession has realised; mycoplasma pneumoniae? coxsackie syndromes?)² The differential diagnosis may be wide, and important pointers are the general wellbeing of the child, their growth, a normal physical examination, together with assessment of their mental state and social circumstances to identify the occasional abused child. Some of these symptoms may be caused by anxiety and other mental health problems, others are perpetuated by them and depressive complications may be present. School attendance may be seriously impaired. Limited investigations are usually needed, and one is often having to break bad news to parents that "the tests are normal". It is not surprising that some of them would almost prefer to receive good news of a potentially life threatening condition. Occasionally one remains uncertain about the diagnosis: a personal clinical review of growth and wellbeing may be more fruitful than further tests or opinions.

Chambers defines semeiology as the study of symptoms. In classical medical diagnosis the assessment of symptoms together with the physical examination and special tests is part of the diagnosis of a disease whose treatment should in turn lead to amelioration or disappearance of the symptoms. Much of the approach in medical education has been to train doctors to decide whether patients have classifiable, treatable "organic" conditions—often by a process of exclusion or "ruling out". In many instances disease is present which medical therapy cures, and symptoms are relieved. However, other patients have complaints which, despite appearing in symptom lists of various diseases, are not found to be caused by any of them. Nonetheless they intrude into a patient's life sufficiently for them to desire their relief. Furthermore, individuals with classifiable disease may have symptoms which are not relieved by treatment of the disease and which tax them and their doctors to the extreme. People with unclassified symptoms and their carers are sometimes unhappy or angry. They sense that doctors are more at ease dealing with disease they can label and treat and are also aware that for some doctors unclassifiable symptoms mean "it's all in the mind" and that referral to a psychiatrist is sometimes reflex and presumptuous.

"Children may experience persistent symptoms"

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The keys to management are respect and belief. Many patients and carers feel that their physicians do not believe them, that they are making up the story or exaggerating it. A minority may be deceiving themselves, their children, and their physicians, but it is surely wrong to treat the majority as though they are behaving like the few. Medical treatment is usually off the evidence based map, has to be explained carefully, and consented to by child and carers. Tension is emerging between symptom sufferers and their advocates who respect anecdote based personal experience and those for whom the only intellectually acceptable therapeutic approach is that sanctioned by the randomised controlled clinical trial.

"Open mindedness is important"

Whichever route one takes (and the wise physician will not be blinkered), reasonable therapeutic objectives should be agreed and they should avoid causing harm. Open mindedness is important: symptoms may be improved by unlikely treatments, including dietary (collaborating with a paediatric dietician), and one has to be alert to medication perpetuated symptomatology such as headaches and analgesic use. Non-specific adjunctive remedies include low dose tricyclic agents for head pain; oxybutynin for urgent bladders; antispasmodics for abdominal pain and bloating (remembering that both they and tricyclics may make constipation worse); occasionally dietary modification, particularly in families where there is a strong migraine history; and rare one offs—cimetidine for incapacitating dysuria, for example. Few, if any, of these medications are licensed for such use in children; this should be explained as part of the consent obtaining process.

Although one tries to achieve a systematic and consistent approach to management, the waxing and waning and interchangeability of symptoms makes this difficult. Frequently one finds oneself imitating Voltaire—entertaining the patient while nature effects the cure. Continuity of physician is a great asset and valued by parents. Many parents consult practitioners of complimentary medicine. If asked for my view, I suggest that they maintain the same critical approach to investigations and treatment, particularly the risk/benefit calculus, as they would to my medical practice. Pain relief services for children are scarce and broader thinking services looking at symptoms as a whole are scarcer. Children and young people like explanations: my practice is to explain that for some reason they have become more sensitive to the aches, pains, and unpleasant feelings we all experience, which are rarely strong enough to trouble us. Their sensitivity is likely to lessen in time, and part (but not all) of the management involves their understanding this and their willingness to try and put such symptoms on one side and concentrate on something else. It

should be emphasised that one does not think they are making them up. If aids to living help, they should be provided. It is not true that once a fatigued child gets into a wheelchair they will never get out.

"School nurses are particularly important"

I doubt if follow up in a hospital based clinic is appropriate for most of these patients. It is better carried out nearer to home, perhaps drawing on hospital services for help with individual symptom control problems. Many get great support from their general practitioners, and school nurses, who are particularly important where there is disbelief among peers which may be expressed through bullying and even, on occasions, adverse pressure from teaching staff. They are best placed to help with home tuition if this becomes necessary. Child and adolescent mental health services may be invaluable, not only in the initial assessment, but also intervening if emotional complications set in. Although part of the basic repertoire of the general paediatrician, any specialist working within or outside the hospital in secondary or tertiary care needs to understand these conditions, those who suffer from them, and their management.

This is a group crying out for advocacy. Woe betide any who dismiss this as uninteresting medicine and them as heartsink patients and carers; you may be a heartsink doctor. Few are more vulnerable than a child being treated for an organ based disorder who develops a chronic symptomatic condition, either as part or separate from it: interspecialty working here is crucial.

Finally research: here is a real challenge for the academic department of general paediatrics, perhaps working with microbiology, general practice, the neuro- and behavioural sciences, and others in collaborative epidemiological and intervention projects of unexplained childhood symptomatology. Who knows, explanations might be found and treatments developed for the most pervasive of "functional" symptoms: how many of the late John Apley's "little belly achers"—a quaintly disdainful sobriquet—had *Helicobacter pylori* gastritis?

This is not an argument for a new specialty with a training programme, accreditation, and all the trappings. Far from it: it is a plea for common sense and open mindedness in the process of assessment and diagnosis combined with a do-as-you-would-your-(grand)child-be-done-by attitude to treatment; not quantum physics but hallmarks of professional good practice. Rather, semeiology might be the catalyst that fuses the healing art with the curing science of medicine: if so, then humanity might have much to thank Callum and his mother for.

REFERENCES

- 1 Anon. It can happen to anyone. *BMJ* 2002;**324**:985.
- 2 Cotterill JA. The devil's grip. *Lancet* 1973;1308–9.