



## CONSULTANT PAEDIATRICIAN AND MEDICAL ADVISOR AT FAMILY FUTURES

by Dr Deborah Hodes and Marilina Antonelou

### Introduction

Children adopted and fostered are being found to have increasingly complicated and serious physical, mental health and developmental problems. Such medical needs should be diagnosed prior to placement in foster care or adoption, and regular health screening appointments should be taking place for comprehensive assessment of their medical, mental/dental health and developmental status. However, some researchers have noted poor health in children not only at the point at which they enter foster care, but also when they leave, compared with their age match controls.

Prior to their assessment at Family Futures, every child will have had frequent contact with nurses and paediatricians; hence all previous and current medical problems should have been identified and the child's past medical history known to their parents and possibly to the child themselves.

However, we wanted to find out whether a paediatric consultation at Family Futures itself would add any benefit for the children and families in the following areas:

- a) *providing* a medical explanation of the problems that contributed to the child's placement difficulties.
- b) *addressing* any current or previous medical concerns
- c) *identifying* any new problems, previously not recognised or diagnosed.

### Methods

47 consecutive cases seen at Family Futures between 2005 and 2009 were analysed retrospectively. Data collection was from both active and archived files: we collected information based on the BAAF (British Association for Adoption and Fostering) proformas.

### Results

- Children were predominantly White-European with the mean age of 8.3 years, range 2-16 years.
- Half (49%) had between 0 and 4 placement changes.
- 38% had between 5 and 9 changes, 11% 10-14 changes and the remaining 2% 15-19 changes.
- 68% of these children were adopted, and referred for the most part to Family Futures because of behaviour problems.
- Carers reported - physical problems (27%): developmental problems (24%): nutritional problems (10%): and behavioural problems (39%).

- In the consultation, the paediatrician discussed management of the problem in 57% of the cases: 30% needed referral for a variety of reasons which included therapy, dietician, specialist opinion by a surgeon whilst only 13% required no action.
- The immunisation history was available in only 77% of the group.
- Very frequently, the paediatrician required further information about the child from the GP, the Looked After Children medical advisor, the community paediatrician and school nurse local to that child's place of residence.

The table shows that 20 new diagnoses were made, many having been present prior to the placement. The paediatrician was able to make new recommendations: for example, a leaflet on psoriasis and explanation of the triggers; dietary advice on constipation; physiotherapy and occupational therapy to improve motor skills in motor dyspraxia; encouragement to participate in sports; advice on bedwetting.

### **New diagnoses in children seen by the Family Futures' paediatrician**

- 1. Foetal Alcohol Spectrum Disorders (FASD)**
- 2. Microcephaly** (A neurodevelopmental disorder in which the circumference of the head is more than two standard deviations smaller than average for the person's age and sex. Microcephaly may be congenital or it may develop in the first few years of life. The disorder may stem from a wide variety of conditions that cause abnormal growth of the brain, or from syndromes associated with chromosomal abnormalities).
- 3. Undescended testes**
- 4. Trigger thumb** (a common, treatable disorder (usually found in later adulthood) characterized by catching, snapping or locking of the involved finger flexor tendon, associated with dysfunction and pain).
- 5. Hypermobility syndrome** (also called "double jointedness" or hypermobility syndrome, benign joint hypermobility syndrome, or hyperlaxity) describes [joints](#) that stretch farther than is normal).
- 6. Coeliac disease** (an [autoimmune](#) disorder of the [small intestine](#) that occurs in [genetically predisposed](#) people of all ages from middle infancy onward. Symptoms include chronic [diarrhoea](#), [failure to thrive](#) (in children), and [fatigue](#), but these may be absent; symptoms in other [organ systems](#) have been described).
- 7. Early onset of puberty**
- 8. Gynaecomastia/karyotype 47xxx (pending)** (Gynaecomastia is the abnormal development of large [mammary glands](#) in [males](#) resulting in breast enlargement: 'karyotype 47xxx' would potentially imply the presence of an extra sex chromosome (genotype XXY) instead of the usual male sex complement (genotype XY).
- 9. Foot length discrepancy secondary to trauma**
- 10. Learning difficulties and behavioural problems**
- 11. Verucca**
- 12. Exclusion of Smith-Magenes syndrome** (A [developmental disorder](#) that affects many parts of the body. The major features of this condition include mild to moderate learning difficulties, distinctive facial features, sleep disturbances, and behavioral problems.

**13. Motor dyspraxia**

**14. Absence seizures as a result of developmental delay** (Absence seizures are brief (usually less than 20 seconds), generalized epileptic seizures of sudden onset and termination)

**15. Vulvovaginitis** (The inflammation or infection of the vulva and vagina)

**16. Hand wart**

**17. Anal fissures**

**Discussion**

None of the carers presented without concerns: and seeing the paediatrician was an opportunity to discuss these. The missing information was important for both the child and parents, providing them, for example, with details of past immunisations. There were new diagnoses for half the children, which needed appropriate management.

In conclusion: despite the children having been seen on many occasions by general practitioners, medical advisors for Looked After Children, social workers and so on, 50% of the children had undiagnosed problems and benefitted from the paediatric review at the time of referral to Family Futures.

**COMMENTS FROM ALAN BURNELL, REGISTERED MANAGER,  
FAMILY FUTURES**

This is a small but important study because it shows that for children who are adopted, but also for some who are fostered, post-placement medical reviews by a Paediatrician should continue at intervals throughout childhood. Some of the diagnoses were clearly minor and common to all children, e.g. warts. However, others were much more serious and related to the consequences of sexual abuse in infancy, neglect and early trauma. Other diagnoses could have been picked up when children came into care. This study highlights how important it is that medical records are kept safe whilst the child is in care and that children were seen not just by local GP, who sees the child now in the context of a new family, but by a Paediatrician who has the full picture and can anticipate the health issues that a child who is in the care system or from the system may be subject to. We do owe these children good and informed medical attention throughout their childhood. My thanks to Deborah and Marilina for the work they have done in highlighting this issue.

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