The general practitioner as paediatrician

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Tony Townsend MB ChB D Obst FRNZCGP MGP graduated from the University of Otago in 1969. He established and developed a suburban General Practice in Rotorua from 1974 until 1994, providing a full range of General Practice services including obstetric care. He moved to the United Arab Emirates in 1994 to an academic career involving undergraduate and postgraduate teaching until 2001 when he made a considered and informed decision to return to rural General Practice in New Zealand.

Infants

My daughter recently gave birth to her second son. Her first baby was a relative breeze – fed, slept and grew. The second is diabolical.

He was irritable and unsettled from birth. When he was about three weeks old Jane noticed a lump on his left shoulder and her GP confirmed a large lump of callus around an over-lapping fractured clavicle.

Her husband had heard a loud crack during the delivery but put it down to her tearing perineum. Surely the fracture must have been the explanation for his irritability and obvious reluctance to lie on his left side.

However the fracture was by now surrounded by callus and obviously stable but Sebastian was still irritable, screaming for hours, not settling after feeds (breast), pulling up his legs, gurgling in his abdomen and passing a good deal of flatulence at both ends.

The diagnosis of infant colic was not difficult. The problem was what to do about it. I knew what I should do as a grandfather – help burp the baby, support his mother and give him back to his parents when he cried too much, but I am glad that I am not their GP.

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Jane has tried all manner of interventions – colic powder, Gaviscon, Infacol, gripe water, ranitadine, feeding for a shorter time, cranial osteopathy and perhaps others that I don't know about, but at six weeks old he continues to have prolonged spells of irritability, cries in pain and refuses to settle at night.

Of course, I also have patients with colic, but I now understand that my suggestions for management have been inadequate.

I decided to look for evidence-based effective treatments. They are hard to find. A systematic review in the BMJ in 1998[1] was evidence-based but not very helpful. They suggested general advice and reassurance (not really of much practical help) and a trial on a hypoallergenic formula (not much help for a breast-feeding mother). They stated that drug treatment has no place in primary care.

Allen Liang's paper published this year[2] is helpful, but I could not find the evidence for his statement that dicyclomine is not associated with cot deaths. I am not disputing it, I just couldn't find it and it is disconcerting that my latest BNF[3] states that dicyclomine is contraindicated under the age of six months.

The problem with this is that if, as a GP, I prescribe dicyclomine and the baby, coincidentally or otherwise, has a severe apnoeic attack or, God forbid, a cot death, I am not sure how I would stand with the Health and Disability Commission, but I can certainly predict the parents' angry response. An enlightening review was conducted by Bandolier last year.[4] They prefaced their review with the comment: 'A frustration with the evidence-based approach can be that it tells us just how little we know. Defining the research agenda is wonderful for academics, but we have a screaming child and we want the answer NOW!

Bandolier has misgivings about evidence when there's actually precious little of it. But infant colic affects up to 150 000 of the children born in the UK every year, and for such a common condition, on balance, a brief reprise of the evidence available probably makes sense.' They concluded their review by stating: 'The

simple fact is that there is no evidence that any intervention is effective. For today's mums and dads all we can offer is the knowledge that their screaming infant will grow out of it.'

Children

I have recently taken on a family of five. Mum, Dad and three boys aged five, seven and nine years. I was somewhat taken aback during the first consultation with Mum when she requested repeat prescriptions for Ritalin for all three boys and for her husband. I spent some time reviewing the family's old medical records (always a frustrating exercise) and found that they had all been assessed, they all met the diagnostic criteria for ADHD[5] and that the family functioning had probably improved as a result of medication.

I accept that the evidence shows that methylphenidate is effective in improving the performance of children with ADHD.[6] However, each month when I write out the repeat prescriptions I have a sense of dys-ease. I do not have the same feeling when writing prescriptions for asthma drugs or insulin. Perhaps it is because Ritalin prescriptions have to be written monthly on special forms; perhaps it is because I can't easily objectively monitor their effect; perhaps the feeling will wear off in time.

Adolescents

A 17-year-old schoolgirl, whom I had not seen before, came with her mother, as she had noticed that her abdomen was swelling and feeling tight.

I have, of course, seen quite a few pregnant schoolgirls before and was about to embark on a sensitive inquiry of totally inappropriate questioning when Mum fortunately asked if I had looked at her previous records.

There, in amongst the correspondence filed shortly before Christmas, was a precise summary: 'Endodermal sinus tumour of ovary T3b with right salpingo-oophorectomy, omentectomy and resection of pelvic lymph nodes with four cycles BEP chemotherapy but without normalization of AFP, followed by two cycles of VIP chemotherapy, followed by ice based autologous transplant procedure, now with progression.'

It didn't matter that I really wasn't quite sure what some parts of this statement meant. I learned that they had been to Mexico for treatment; I didn't ask about the details. I asked if I could examine her abdomen and confirmed that she had ascites (shifting dullness) and a hard craggy mass low in her pelvic region. I arranged some further investigations. I am sure that each of us knew what was going on but none of us talked about it. Some things are just too hard.

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General practitioners

When reflecting on 30 years of experience as a general practitioner with paediatric patients I realised that my difficulties were not about making a diagnosis. Not that assessment is always easy, but time and our paediatrician colleagues help us with that.

It is not with the practice of evidence-based medicine. Sometimes the evidence helps, sometimes it hinders and often it doesn't exist. Rather, my difficulty is in maintaining an ongoing therapeutic relationship with the young person and her or his parents or carers when I am flying by the seat of my pants. When my clinical skills are stretched while trying to foster a relationship in situations for which 'medicine' has little to offer. For those common, temporary illnesses for which we buy time (or perhaps the health care system buys our time) while nature does the healing. For those genetically determined behavioural disorders that most of us don't yet feel very comfortable with. For those devastating illnesses that shatter the lives of all those involved, some much more than others. These are the situations that test the skills of the general practitioner as a paediatrician and challenge us to continue to develop our discipline.

References

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