Death, Bereavement, Pain
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Pain management for children, death and dying, bereavement issues, and combining curative and palliative treatment of children with life-threatening conditions comprise the topics of the set of articles in this issue of Pediatric Annals.

Reviewing these articles led me to recall my medical school rotation on psychiatry as a third-year student at the University of Chicago. My small group seminar leader was a young woman instructor with a Swiss-German accent who spoke eloquently and passionately about the grieving process. Years later I learned that Elisabeth Kübler-Ross, MD, (1926-2004), had become quite famous, with her book On Death and Dying published in 1969 establishing the five stages of grief: denial, anger, bargaining, depression, and acceptance.

She went on to write many other books, was awarded 20 honorary degrees, and revolutionized thought regarding death, dying, and the grieving process. Several of the articles here make these concepts relevant to the pediatrician’s activities, emphasizing the effect of illness upon the family and upon caregivers as well.

My clinical and research activities are focused largely upon our Kawasaki-disease (KD) population of 50 to 70 new patients annually. The unexpected and sudden death of a 5-year-old patient with KD, our only KD fatality in 30 years of caring for a very large number of these patients, was very traumatic, of course, for the family but also for the caregivers. We all grieved.

I urge you to read particularly the article by Dr. Amy Durall (page 266) on “Care of the Caretaker.” This article discusses these issues and deals with complications of caregiver grieving like compassion fatigue and burnout, emphasizing the importance of a supportive clinical team and maintaining a work environment conducive to expressing emotions.

Loeffler (1852-1915) was a Prussian army surgeon and outstanding microbiologist who graduated with his MD degree from University of Berlin and worked with Robert Koch from 1879-1884 during the early days of bacteriology. He developed a number of bacterial growth and staining techniques and sterilization procedures. He is most famous for discovering the agent of diphtheria, originally called the Klebs-Loeffler bacillus, now Corynebacterium diphtheriae, in 1883-4, as well as the viral agent of hoof and mouth disease of cattle, a picornavirus of the genus Aphthovirus. This was the first discovery of a disease caused by a filterable agent, (ie, a virus), in 1899. Loeffler actually described what is now called Koch’s postulates.

This 2010 German stamp honors Friedrich Loeffler (1852-1915) and the research institute that now bears his name. From the collection of ST Shulman.
a year before his mentor Koch wrote his famous description.

The Friedrich Loeffler Institute was founded in 1910 and was named for its founder Loeffler in 1952. Situated on the Isle of Riems near Greifswald, Germany, it is the German national research center for animal health, which it just constructed the most modern animal health research facilities in the world. Its emphasis is on the study of viral infections of animals including avian influenza. To the right of Loeffler’s portrait on the stamp is an influenza viral particle.

The large French souvenir sheet celebrates the French Red Cross, and the individual stamps portray (left to right) phoning emergency services, care of an unconscious patient, performance of the Heimlich maneuver, and cardiopulmonary resuscitation (CPR). Along the top are copies of old posters that highlight Red Cross activities with slogans encouraging the public to join the Red Cross, to become a first aid worker, and “Everyone needs you.” The French Red Cross (Croix-Rouge française) was formed in 1940 by the merger of three organizations including one dating to 1864 and the First Geneva Convention.

I would also like to comment on the Case Challenges column in the April issue, “A 5-year-old Boy with Fever and Rash” [Pediatr Ann. 2011;40(4):185-187]. All physicians who provide care for children need to be aware of the concept of “incomplete or atypical Kawasaki disease.” This refers to children who have at least 5 days of fever associated with only two or three rather than four or five classic KD features and who lack an alternative diagnosis.

The Committee on Rheumatic Fever, Endocarditis and Kawasaki Disease of the American Heart Association (AHA) has published an algorithm (also endorsed by the American Academy of Pediatrics) to provide guidance for this group of patients. This is an important group because these incomplete KD patients, if not treated, are at the same risk for coronary artery complications as are typical KD patients.

In the algorithm, patients with more than 5 days of fever and two or three KD features are triaged with inflammatory markers (sedimentation rate, C-reactive protein level). If the CRP is greater than 3 mg/dL (or greater than 30 mg/L) and/or the ESR is greater than 40 mm/hr, KD should be suspected and the patient screened for supplemental lab features that can support the diagnosis of KD. These include: 1) WBC greater than 15,000/mm³; 2) anemia for age; 3) platelet count after the 7th day of illness greater than 450,000/mm³; 4) albumin less than 3 g/dL; 5) urine with greater than 10 WBC/HPF; and 6) elevated ALT level. The presence of at least three of these lab features supports the diagnosis of KD and should prompt an echocardiogram. The presence on echo of features suggestive of KD, such as pericardial effusion; mitral regurgitation; decreased left ventricular function; coronary artery Z-scores of 2 to 2.5; or perivascular brightness of the coronary arteries, is strongly suggestive of KD even in the absence of coronary aneurysms, which typically are not apparent before the 10th illness day.

I urge all pediatric providers to review the position paper cited at left, especially Figure 1, which is the clinical algorithm. Our pediatric infectious diseases fellows carry this on rounds, as they need to consult it frequently.

**REFERENCE**


doi: 10.3928/00904481-20110412-01