Common and Frustrating Patient Management Problems

Kenneth Alexander, MD, PhD

This issue of Pediatric Annals examines some of the common and often frustrating problems that pediatricians who work in primary and urgent care encounter on a daily basis; frequently, primary care physicians consult with subspecialists in various fields to get a fuller picture of what may be occurring with a child’s health status.

Certainly, there is no shortage of challenging situations from which to pick, ranging from the child who is “sick all the time,” to the child with aches and pains, to the depressed adolescent, and to the child with tympanostomy tubes and chronically draining ears. The list goes on and on. Because there is often not a “quick fix” option to the chronic symptoms, many of these clinical scenarios are worrisome for all involved—the physicians, the children, and the parents.

Initially, as I approached my colleagues asking them to write about these experiences in their practice, their initial responses were lukewarm. “Why would I want to write about that?” they asked. As I explained that our goal would be to help our colleagues deal confidently with things that they found every bit as frustrating as we do, they became more interested. My sole instruction to the contributors as they began to write was “make it useful.” I think they have done just that.

In the first article, “Badly Behaving Noses in Children: Rhinitis, Sinusitis, or Neither?” Drs. Jordan Smallwood and Julie L. Wei write about the chronically drippy nose. Who better to think about this than an otolaryngologist and a pediatric allergist? In their article, you will find not only many of the concepts with which you are familiar (antibiotics still don’t help very often), you will also find some new ideas that the authors themselves are beginning to examine more closely. I would encourage clinicians to obtain a dietary history for children with persistent rhinitis. Look closely at sugar consumption, in the forms of juice, cookies, and sweetened yogurt products. Also ask about both evening hours and bedtime milk consumption. Maybe there are connections between excessive sugar consumption, eating or drinking dairy products before bedtime, and badly behaved noses.

In the second article, “Difficulties in the Diagnosis and Management of Functional or Recurrent Abdominal Pain in Children,” Dr. Roberto Gomez-Suarez discusses chronic abdominal pain. When I was a medical student, I remember reading Cope’s Early Diagnosis of the Acute Abdomen.1 For those who are unfamiliar with this book, it is perhaps the classic treatise on diagnosis of the acute abdomen. To my young medical-student mind, this book made the assessment of abdominal pain seem like something of a cross between a chess match and a walk through a minefield; everywhere were challenges and hidden dangers to consider if I was to do right by my patient. Almost 30 years later, I’ve come to appreciate that not all abdominal pain is acute abdominal pain, that chronic and recurrent abdominal pain are difficult to sort out, and that not all abdominal pain in children arises from definable anatomic, physiologic, or infectious problems. Although I feel certain that Dr. Cope may have emphasized the importance of psychologic and social histories in the assessment of the acute abdomen, the importance of thinking outside the abdomen for causes of chronic and recurrent abdominal pain didn’t come to me until later in my career. Dr. Gomez-Suarez presents a useful way of thinking about all this. He shares with the reader how to think about chronic and recurrent abdominal pain—what red flags to look for, when we need to refer for specialty care, and when we need to sit back and listen.

“She just won’t stop crying!” These are hard words to hear from young parents, and whether you are in an office, in an urgent care clinic, or in an emergency department in the wee hours of the morning, these words give us all pause. The baby who won’t stop crying is a problem of sensitivity and specificity all wrapped up in parental fear and frustration. No one likes to hear their child crying, and yet this is exactly what normal babies do. As pediatricians trying to help families with crying babies, we have four tasks: (1) make sure there...
isn’t something really bad going on (no meningitis, no retinal hemorrhages, no broken bones, nothing causing severe pain); (2) try to identify the cause of the crying; (3) make sure that the child is safe (crying babies are at high risk of being maltreated); and (4) educate parents that crying is normal (show them how to recognize abnormal crying and teach them how to deal with their own parenting frustrations when the child cries). In the article, “Emergency Department Triage of the ‘Incessantly Crying’ Baby,” Drs. Caroline Chua, Jennifer Setlik, and Victoria Niklas (two neonatologists and an emergency medicine physician) have given us a framework for how to think about children who cry constantly. I can imagine a copy of their article tacked up on a bulletin board in an emergency department.

Then, there’s the matter of hives. It comes as no surprise that urticaria can be distressing to parents as well as to children. Giant blotchy wheals appear mysteriously on the skin of children. They have to have a cause, right? Was it something she ate? Was it the new lotion? Was it the new laundry soap? It had to be the amoxicillin. Maybe her chakras are out of alignment. Parents and pediatricians want to know the cause of urticaria. As a consequence, it is not uncommon for children with urticaria to show up in allergy clinics having had thousands of dollars of testing performed, all to no avail. In his article, “Urticaria: ‘You’re Probably Just Allergic to Something,’” Dr. Smallwood gives us a clinically sensible approach to children with recurrent urticaria. In short, it’s not about the cause, it’s about the treatment.

With this interesting assortment of articles in hand, there came the challenge of giving the collection a unifying title. My immediate thought for an overarching title was “Diagnoses We Hate.” Certainly, at times, we feel that way with some of these problems. Then I heard in my head the voices of my parents reminding me that hate is a very strong word, and that it is always best not to have your name and the word hate in the same sentence. Bad idea. “Challenging Patient Management Problems” crossed my mind, but this title was bland and nonspecific. “Common and Frustrating Patient Management Problems” is where I settled; not flashy or evocative, but as a title, it gets the job done. Having just checked the news headlines on my phone, I saw the word “hate” come up in an article about the ongoing presidential campaigns. Mum and Dad were right; best not to have your name and the word hate in the same sentence. Please enjoy the work of my colleagues, bound together under the title “Common and Frustrating Patient Management Problems.” I think you’ll find their work useful.

**REFERENCE**


Disclosure: The author has no relevant financial relationships to disclose.

doi: 10.3928/19382359-20161014-01

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**About the Guest Editor**

**Kenneth Alexander, MD, PhD**, completed his medical and graduate training at the University of Washington in Seattle. After his residency training in Pediatrics at the Children’s Hospital in Boston, Dr. Alexander did fellowship training in Infectious Diseases at Duke University. After 10 years on the faculty at Duke, Dr. Alexander moved to the University of Chicago where he served as chief of the section of *Pediatric Infectious Diseases*. In 2014, Dr. Alexander moved to the new Nemours Children’s Hospital in Orlando, FL, where he currently serves as Chief of Infectious Diseases.

Dr. Alexander’s clinical interests include infections in the neonatal intensive care unit, and vaccination of underserved populations, particularly adolescents. He has a special interest in promoting human papillomavirus immunization. Dr. Alexander’s research studies papillomavirus replication and HPV-mediated oncogenesis.

Dr. Alexander and his wife, Michelle, of 31 years have two adult daughters who are outspoken advocates for immunization.

Address correspondence to Kenneth Alexander, MD, PhD, via email: Kenneth.Alexander@nemours.org.