

SUBSPECIALIST CONSULT

The Child or Adolescent With Anxiety

Identification of children and adolescents with anxiety is important, so consider the diagnosis in your differential. Always think: Could this be anxiety?

Pediatricians are well trained to rule out medical or other causes of anxiety. Questions to ask include: Is the child hypoxic? Does the patient have hypothyroidism? Is the anxiety caused by stress or social factors, including sexual and/or physical abuse? Do the symptoms come from a general adjustment disorder from a major life change or event, such as a move or divorce?

Does the patient have a secret she is afraid to share with anyone else? A shy child, for example, may have something she is afraid to discuss that, together with stressors, can lead her into a true anxiety disorder.

Panic attacks, in particular, can be clinically challenging. Is the attack anxiety driven or caused by an underlying medical problem? We tend to minimize cardiac symptoms, for example, in some children because it is easier to say these symptoms are related only to anxiety. But we need due diligence to rule out any major cardiac or pulmonary etiologies.

When screening patients for anxiety

disorders, child and adolescent psychiatrists use comprehensive instruments like the Screen for Child Anxiety-Related Emotional Disorders (SCARED). In a busy primary care setting, I would recommend that pediatricians use the SCARED tool. It is available at no cost and features separate rating scales that can be completed by the child and parent.

For a more comprehensive screening tool, use the Child Behavior Checklist (CBCL), the Child Symptom Inventory (CSI), or the Behavior Assessment Symptom for Children (BASC). Other screening instruments are available that are more disease specific, such as the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) for obsessive-compulsive disorder (OCD).

It is appropriate for pediatricians to manage the treatment of an anxious child or adolescent when the patient is stabilized and continues to improve with treatment. In this way, a child with anxiety is managed no differently than a patient with asthma or diabetes.

Some pediatricians refer a child with a suspected anxiety disorder for an initial evaluation by a mental health specialist such as a child and adolescent psychiatrist, followed by annual consultations. We are

happy to consult with pediatricians. One challenge, however, is an overall workforce shortage of child and adolescent psychiatrists. The American Academy of Child & Adolescent Psychiatry offers an online map of the United States that shows the number of specialists per county (www.aacap.org/cs/physicians.Allied-Professionals/workforce_issues).

When is it appropriate for a pediatrician to initiate medication in this patient population? Any time it is indicated! And that really depends on the diagnosis: for OCD, yes; for PTSD, maybe; and for social phobias, probably not. Medication use also is based on symptom severity, especially in generalized anxiety disorder. If the child is not sleeping well or participating in activities of daily living, you have to get him or her stabilized first. The bulk of our treatment for anxiety disorders is psychotherapy, but the child is less likely to benefit from therapy if anxiety impedes the ability to participate in therapy.

Referral to a specialist is indicated when anxiety symptoms interfere with activities of daily living. School refusal is another scenario that warrants immediate referral. Some parents will allow anxious children to stay out of school, so try to determine the reason: Is the parent making it more comfortable for the child to stay at home? Or is the patient avoid-

ing school because they are the target of teasing?

Copies of a recent physical examination, growth chart, and any laboratory work already ordered are helpful with a referral to a child and adolescent psychiatrist. In addition, a detailed clinical assessment facilitates management by a child and adolescent psychiatrist. In other words, it is helpful to get a note that states: "Referring Johnny to you. He was a developmentally normal 5-year-old until he nearly drowned in a pool last summer. He now refuses to sleep alone." In contrast, a less helpful note might read: "Here is a 5-year-old named Johnny. Please assess."

Unless you suspect a true organic etiology, such as an abnormal neurologic examination, avoid ordering routine imaging studies for a child with anxiety prior to referral. I am concerned about the risks of sedation for pediatric patients and risks associated with radiation exposure (with CT scans, for example).

Avoid excessive laboratory testing as well, unless there is a clear indication that results could rule out a suspected medical diagnosis.

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BY SHARON L. HIRSCH, M.D.

Allowing Body Checks Tripled Ice Hockey Injuries in Kids

BY MARY ANN MOON

FROM JAMA

For 11- and 12-year-olds who play ice hockey, playing in a league that allows body checking triples the risk of all injuries, concussion, severe injuries, and severe concussion, according to a report in JAMA.

Compared with leagues that do not permit body checking, those that allow it also show twice the rate of injuries from other types of intentional contact, reflecting a generally more aggressive style of play, reported Carolyn A. Emery, Ph.D., of the Sports Medicine Centre and the pediatrics department, University of Calgary, Alberta, and her associates.

Body checking is using the body to knock an opposing player against the boards or the ice.

More than 550,000 youths are registered to play ice hockey in Canada, and more than 340,000 are registered in the United States. The age at which body checking is introduced varies internationally, and also varies between locales within each country, the investigators said.

Ice hockey injuries comprise

10% of all sports injuries incurred in the pediatric population. Dr. Emery and her colleagues compared patterns of injury during the 2007-2008 season in what they described as "the first prospective cohort study using a validated injury surveillance system, including [a physio- or athletic] therapist and physician assessment, to examine the risk of playing in an ice hockey league that permits body checking compared with one that does not."

Their study sample included boys and girls aged 11-12 years in the top 60% by level of play. A total of 1,108 study subjects played for 74 teams that allowed body checking, and 1,046 subjects played for 78 teams that did not. The median time spent in practice sessions and playing games was not significantly different between the two groups.

There were 241 injuries, including 78 concussions, where body checking was allowed, compared with 91 injuries, including 23 concussions, where body checking was not allowed.

"Our results indicate a greater than threefold increased risk of concussion, injury, severe con-



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cussion, and severe injury in game play" in leagues that permitted body checking, compared with leagues at a similar level of play that did not permit body checking. There was no difference in rates of practice-related injury, the researchers said (JAMA 2010;303:2265-72).

The greatest disparity in injury rates was for concussions and fractures, which is "not surprising, given the mechanics of body checking." However, the risk of injuries due to other forms of intentional contact

also was twice as high in the leagues that allowed body checking, they noted.

As has been reported in previous, smaller studies, rates of injury and concussion were highest among children who had sustained previous injuries and concussions. "This may be related to incomplete healing/rehabilitation, susceptibility of a player to injury based on other factors (e.g., on-ice behaviors), or both," Dr. Emery and her associates wrote.

Of particular concern was the

finding that many players who sustained concussions failed to follow up with a physician. In leagues that permitted body checking, only 39 of 78 players (50%) who sustained a concussion followed up with a physician. That rate was somewhat higher, at 61% (14 of 23 players), in leagues that did not allow body checking. This lack of physician follow-up was considered a limitation of the study.

The study findings have important implications for both athletic policies and public health.

"This research can inform the development and rigorous evaluation of prevention strategies to reduce the risk of injury in the population of youth ice hockey participants," the investigators said.

Funding for the study included the Canadian Institutes of Health Research and the Max Bell Foundation. Dr. Emery reported receiving support from the Alberta Heritage Foundation, the Canadian Institutes of Health Research, and the Alberta Children's Hospital Foundation. No financial conflicts of interest were reported.