Leading Article

Functional, non-organic symptoms in children and young people

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Chambers Dictionary defines functional as: "characterised by impairment of function, not of organs". Organic disease is one "accompanied by changes in structures involved" – presumably those structures might also be genetic, biochemical, immunological or organs which have been damaged by malfunction of those non-anatomical influences. Non-organic symptomatology – or semeiology, to be precise - is therefore unaccompanied by structural change. Such symptoms make up a large part of the work of doctors at all levels of care, may result in severe incapacity of sufferers and their families and may lead to serious misunderstanding and disharmony between the patient/carers and the health professionals. The 20th century specialist paediatrician's approach was often "rule out and discharge" – perhaps to a child psychiatrist. The child/young person's views may not have been taken account of and the parents felt there were no alternative options. 21st century medicine is about patient and carer empowerment, choice and the validity of the patient experience. It is time to recast our thinking about this group of conditions and recognise them as general medical rather than primarily psychological.

Common childhood* symptoms which present to primary care physicians, either together or singly include pain (head, chest, abdominal and limb), tiredness, light-headedness, sweatiness, nausea, double vision, sensitivity to light, noise and touch, and others. All of them are listed in the symptomatic diagnostic workup list for many organic diseases. The seasoned diagnostician relies heavily on a careful history concerning these and other complaints in formulating a provisional diagnosis. Likewise a thorough physical examination not only reassures the patient but also the doctor that it is unlikely that there is an organic condition present. Pointers to functional conditions include hyperaesthesia to skin touch, and multifocal symptoms and pain sites with normal examination findings. From such a painstaking and methodical clinical examination a discerning choice of investigations may be made. Some adopt a rule-out approach and arrange a large number of laboratory and imaging tests "just in case". The drawback here – not including the cost of such a policy – is that tests may give equivocal results and then lead to further, more expensive, invasive and hazardous procedures. Tests should come as a result of asking precise clinical questions whose answers will influence management. Few would do none, but going beyond a blood count, acute phase protein, urinalysis and perhaps renal and liver function risks trouble for patient and doctor. Things may be more difficult if functional symptoms complicate a pre-existing classifiable disease. Although the general medical assessment should include mental and emotional health, in selected cases I explain to patients and carers that a psychological assessment is just as important a test as a scan because mental illness may have somatic symptoms. However I emphasise that – as with other tests - it is done with an open mind in order to assist in diagnosis.

It should be easy to make a diagnosis of a functional condition at a single consultation, particularly if the clinic organisation is "one stop". One may then engage the patient and carers in a discussion about the cause of the symptoms as soon as possible. This discussion may be troubled: is it good news to learn that symptoms which might have led to school non-attendance, family disruption and refocusing and an unhappy and bewildered young person do not have cause for which there is specific treatment? Some families take it as bad news. Much depends on how the physician handles that crucial consultation. The patient and family must not get the impression of professional disbelief in the symptoms, disparagement or disengagement. Just as with all other medical conditions a firm and positive diagnosis should be given, and explanation of why the symptoms occur and what needs to be done about them. My approach is to explain that much of what afflicts people does not have a serious or scary cause, for example needing a hospital stay or an operation – although functional symptoms resulting in prolonged

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school absence *are* serious. Moreover, the nervous system may experience unpleasant feelings both when there is identifiable disease present and when not – the phantom limb example is sometimes helpful. At this stage it is vital to get agreement from all that the diagnosis is understood, acceptable and one from which symptomatic treatment might follow. If this is not so then the doctor will have to explore why and how agreement might be achieved: this might mean a further test – perhaps to make sure a condition that causes specific anxiety is not present – or another opinion. If this is done with sympathy and authority (not authoritarian-ness) in partnership with patient and carers it is constructive. If it results from friction, professional hubris and the striking of attitudes, particularly between doctor and parents, no good will come, least of all to the patient.

Management of functional problems is by (re)habilitation. A team approach may be helpful: therapists to address the specific incapacities, including disinclination to eat (dietitian), contact with education so that the young person may remain in touch with school even if they cannot attend fully. In this and all other aspects of habilitation it is imperative to go at the patient's pace – indeed one might argue that this is a basic right of young people. It is duplicitous to tell a person one believes in their incapacities and then impose treatments which they cannot tolerate. Young people seldom experience gain from their problems and want to be back to their old selves. No harm comes from such an approach. In this and all other chronic paediatric conditions psychological support is important. This is provided by the family and the general paediatrician but may often be usefully supplemented by focussed psychological or psychiatric input. One should remember that chronic illness may lead to depression which needs skilled treatment in its own right. Occasionally physical interventions are needed – splints, TENS machines for example. Pain should be managed proactively: if simple analgesics do not work then pain modifying drugs such as anticonvulsants service may be needed. If there is access to a paediatric pain and symptomatology team, so much the better. However the generalist should remain involved with the patient to co-ordinate services, review with an eye on complications and advocate on the patient's behalf. Of course many patients will not need the full service of a multidisciplinary team: they, the paediatrician and the parents will work with simple behavioural and pharmacological tools to achieve success. Complementary medicine and other interventions are used widely in the UK; my view is that if they are found to be beneficial, so be it – but do not reject the patient because they roam wider than your patch: be there to support them – and to put the internet into perspective.

A word about child protection. In some children functional symptoms may result from abuse, physical or emotional. Moreover, the attitude of some families to their child's symptoms might suggest factitious illness. Some might regard the parents of a functionally ill child who solicit multiple medical opinions as being *de facto* abusive (despite the professional collusion that it sometimes revealed). None of this can be denied but the magnitude of this problem seems small and it would be wrong and dangerous to assume there is abuse just because incapacitating symptoms present without any obvious cause. If there are well founded concerns local child protection policies should be followed.

Functional conditions are rewarding to work with: they challenge parts of paediatrics that organ oriented specialties do not reach and they are for the open minded and clinically ingenious physician. This is because medical history is littered with examples of functional conditions for which an organic explanation emerges: how many of Apley's "little belly-achers" had H Pylori gastritis or non-coeliac wheat intolerance? It is therefore also an important area for research, especially interdisciplinary. It lacks great evidence base; clinical pathways are not well trodden and the doctor may sometimes feel professional loneliness (but not as lonely as a parent of an unwell child who feels ignored or demeaned). However our medical paediatric calling expects that we should stick with and help these children and their families – they may have nobody else to turn to.

* I use the term child, children or childhood as shorthand for children and young people.