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Medicine

THE IMPORTANCE OF ANAMNESIS IN PEDIATRICS

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ABSTRACT:
ANAMNESIS, OR PHYSICIAN-PATIENT DISCUSSION, HAS REMAINED AN ESSENTIAL AND PRELIMINARY STEP FOR ESTABLISHING A CORRECT DIAGNOSIS SINCE HIPPOCRATES. THE RISK OF POSSIBLE ERRORS SHOULD BE MINIMIZED BY PROVIDING SOME PARAMETERS: ACCURACY, GOING THROUGH "CHRONOLOGICAL" INTERVIEWING PHASES, EMPATHY TOWARDS THE PATIENT AND CARETAKERS, PROVIDING A CALM ENVIRONMENT WITHOUT DISTURBANCE, WITHOUT DISTURBANCE, ADAPTING MEDICAL LANGUAGE AND USING DISCERNING MEDICAL TERMS ACCORDING TO THE PARTICULARITIES INTELLECTUALS OF THE INTERLOCUTOR.
NOT COMMITTING TO ANY STAGE, ACCURATE AND USEFUL INFORMATION COLLECTION HELPS TO QUICKLY APPLY PROPER TREATMENT, SHORTER HOSPITALIZATION, AND EASIER RECOVERY OF THE PATIENT, THE MORE IT IS ABOUT A CHILD.

KEYWORDS; ANAMNESIS, CHILD.

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Anamnesis is all the information about the patient or his / her entourage related to the state of health or disease obtained by the physician, following the dialogue. Pediatrics, as a distinct specialty, having a child, an immature body with no discernment until the age of 18, attaches great importance to the collection of in-depth information about the patient, information obtained almost exclusively from other family members, often marked of great subjectivity.

The doctor-patient binomial relationship, common to all other medical activities and specialties, is no longer respected in Pediatrics.

Interactions are multiple, subjective reports, deliberate neglect or not communicating important information, and implicitly, precious information may be lost to elucidate the diagnosis. The work and medical thinking are aggravated, the work of the doctor takes over detective notes, and the time spent in the anamnesis may increase significantly, possibly with returns in the coming days or during hospitalization[9].

The high degree of subjectivism, the stress caused by the child's illness, alters the attitude of the parents (the relatives) in relation to the treating physician.

Reticence, communication of precious information (other family affections, poisoning, child abuse, etc.) can direct medical thinking in a dangerous, non-conforming direction, delay or stop the correct diagnosis and the uninterrupted establishment of appropriate treatment[10].

The pediatrician, in addition to doctors in other specialties, must show empathy, translate into the excitement of the parent, pay attention to it, repeat fragments of phrases in order to gain confidence and make sure he understands description made. The language will be appropriate to the degree of training, intelligence and emotion of the parent-interlocutor. The doctor must be a fine psychologist capable of "molding" the intellectual and emotional abilities of the dialogue partner[11].

The doctor should be calm, quiet, undisturbed, in a pleasant and relaxed setting. The tone of the conversation must be kept “stable", the dialogue must flow fluidly, without syncope, in order not to create suspicion. The doctor should be able to avoid time and energy-consuming "traps", focusing on the "steps" needed to complete the medical interview.

The escalation of subjectivism and mistrust can be done by apparently giving up the questions considered "inconvenient" by the family and returning to the subject, in another form and in another register. For example, many families show maximum reluctance in chronic clumsiness, and pulmonary tuberculosis is, almost without exception, hidden and not communicated for the purpose of pediatric anamnesis, not necessarily of ill-will, notably unconscious of implications or sensation culpability and guilt or a sense of negation of assuming a chronic illness and a lasting treatment. The question, in this case, will not be "Do you have

[9] Lau HS, Florax C, Porsius AJ et al. The completeness of medication histories in hospital medical records of patients admitted to general internal medicine wards. Br J Clin Pharmacol 2000;49(6):597–603. doi: 10.1046/j.1365-2125.2000.00204.x

[10] Tam VC, Knowles SR, Cornish PL et al. Frequency, type and clinical importance of medication history errors at admission to hospital: a systematic review. CMAJ 2005;173(5):510–515. doi: 10.1503/cmaj.045311

[11] Dornan T, Ashcroft D, Heathfield H et al. An in depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education. EQUIP study final report December 2009. Available at: http://www.gmc-uk.org/about/research/25056.asp (accessed January 2016).

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tuberculosis in the family?" But "Are there adult members of the family, friends, frequent visitors with persistent or chronic coughing in contact with the child?"[12].

The anamnestic interview, in essence, is standardized and structured according to some "steps", valid in all specialties. Reasons for admission refer to the symptoms (objectives) that mobilized the family to bring the child to the doctor. The age of the child (newborn, infant, preschool, school child, etc.) is a major factor of subjectivism in perceiving symptoms by the family. Parental anxiety is inversely proportional to the age of the child and, often false, the pathology agglomerates the guard rooms in the pediatric wards. The normal manifestations of age (eg regurgitation of the newborn or small baby collics) are hyperbolically perceived by the family / mothers without experience, education, previous documentation or uninformed in the maternity[13].

The doctor is obliged and responsible for thoroughly consulting each child for family reassurance and counseling of parenting tips and guidance. This seems to be appropriate for primary care or in the form of counseling hours, organized antepartum or maternity. Newborn physiology, the role of natural nutrition, incidents and physiological variations must be explained but also easy to understand for mothers. This can limit the agglomeration in waiting rooms of pediatric wards, the contact of healthy children with the sick, and last but not least the overwork and the appearance of the "burnout" syndrome that places pediatricians in the top of professions affected by major stress.

The admissions reasons will be briefly and succinctly stated in the field of the observation sheet dedicated to them.

The heredocolateral antecedents refer to questions about existing affections within the family, to third degree relatives. Questions will address hereditary genetic disorders (thalassemia, haemophilia, muscular dystrophy, dysmetabolic diseases, familial disorders, etc.).

Personal physiological history refers to the "constellation" of factors that are related to the physiological condition of the child.

To ease the interview and avoid syncope or return to dialogue, it will be structured on the principle of chronology. Preconception, conception, pregnancy, birth, newborn, diet, diversification, childhood, puberty, menarche (girls), vaccination schedule, etc. will be covered.

It concerns the condition of preconception for both partners of the couple, the gynecological problems of the mother (urogenital infections) that can affect the local balance and cause changes in the structure of the local flora and even the risk of premature birth (the association of M. hominis, Gardnerella vaginalis, Atopobium vaginae).

The pregnancy modality (natural or fertilization procedures), the pathology of the pregnant woman, knowing the increased risk of fetal malformations during the organogenesis period (the first 2 weeks), the occurrence of gestational diabetes, eclampsia, preeclampsia, the risk of abortion, interest in environmental factors, stress, pregnancy activity. Birth time will be quantified in a number of ways: pregnancy duration, birth rate (the higher the risk associated with low birth weight or early anemia), birth weight, Apgar score (a 5-point cumulative which shows the condition of the skin, muscular reactivity, breathing, cardiac activity, is assessed at birth and at 5 minutes A score below 8 suggests a neonatal adaptation deficit and requires neuropsychiatric consultation

[12] Douglas G, Nicol F, Robertson C Macleod's Clinical Examination. Eleventh edition. 2005 Churchill Livingstone, Edinburgh

[13] Department of Health. Good Practice in Consent Implementation Guide: Consent to Examination or Treatment. 2001 The Stationery Office, London.

from the age of 3 months later. If necessary, an Apgar score under 5 means multiple impairment with neonatal adaptive deficiency. It is important the type of diet (natural or artificial), the moment of diversification, the presence of physiologic jaundice, the prophylaxis of rickets (duration, doses), the vaccination schedule.

Personal pathological antecedents should have the same chronological path: prenatal, perinatal, and postnatal.

Prenatal is potentially interested in the "uterus" solved pathology (reducing the total number of fetuses in multiple pregnancies or suppression of an aberrant embryonic vessel, in twin transfusion ratio / transfused twin, or correction of severe cardiac malformations, etc.). Perinatally interested in reanimation maneuvers, applied treatments, prolonged hospitalization, oxygen therapy, incubator placement, prolonged phototherapy, the risk of retinopathy of prematurity. Postnatal concerns the totality of the pathology the child suffered until the time of admission. Emphasis is placed on repeated hospitalized diseases, infectious-contagious diseases, congenital malformations, chronic conditions (eg bronchial asthma), surgical interventions (adenoidectomy, appendectomy, corrected congenital heart defects, etc.)

The living and working conditions refer to the number of persons / room, type of dwelling, heating system (wood stoves, gas, electricity), noxes (smoke, dampness, moisture, dust), hygiene, bath placement inside the dwelling or type of latrine.

Family behaviors will be specified (smokers, alcohol users, drugs), food taboos (vegetarian or raw vegans) with multiple deficiencies in children (anemia, dystrophy, protein-calorie malnutrition). Treatments administered until the time of admission concern the type of substance administered, doses, duration, administration of therapeutic regimens, chronic disease therapy.

The history of the disease refers to the chronological description of events, signs and symptoms from the time of the disease until the time of admission. Also here is the way in which the admission is made (urgent, through the clinic, from GP with a referral ticket).

The time spent on the anamnesis is 15-20 minutes, the climate must be neutral, the calm, relaxing tone, the empathic and understanding attitude and the discussion adopted at the intellectual level of the interlocutors. The chronological interview should be conducted in order not to miss important steps and to guide medical thinking to establish a correct and rigorous diagnosis and to establish uninterrupted treatment. Any anamnesis "trap" may adversely affect the physician and the patient at the same time in order to establish an erroneous diagnosis[14].

The following steps: physical examination, paraclinical investigations, appropriate treatment, depend on the accuracy of the first stage - anamnesis.

CONCLUSIONS

The importance given to the anamnesis is undervalued in all specialties, especially in pediatrics. It should be reconsidered and repositioned correctly, the pediatric patient being "sensitive" in terms of age, compliance, discernment, anamnestic and immunological particularities.

[14] Hurley KJ. OSCE and Clinical Skills Handbook. 2005 Saunders Elsevier, Ontario.
7 Shah N Taking a history: introduction and the presenting complaint. Student BMJ 2005. 13, September, 309-352.

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The homogeneity and coherence of information shapes the clinician's thinking, reduces the risk of diagnosis and treatment errors, implicitly shortens the duration of hospitalization and the risk of nosocomial infections, complications of hospitalization in general.

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REFERENCES

1. **Lau HS, Florax C, Porsius AJ et al.** The completeness of medication histories in hospital medical records of patients admitted to general internal medicine wards. Br J Clin Pharmacol 2000;49(6):597–603. doi: 10.1046/j.1365-2125.2000.00204.x
2. **Tam VC, Knowles SR, Cornish PL et al.** Frequency, type and clinical importance of medication history errors at admission to hospital: a systematic review. CMAJ 2005;173(5):510–515. doi: 10.1503/cmaj.045311
3. **Dornan T, Ashcroft D, Heathfield H et al.** An in depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education. EQUIP study final report December 2009. Available at: http://www.gmc-uk.org/about/research/25056.asp (accessed January 2016).
4. **Douglas G, Nicol F, Robertson C** Macleod's Clinical Examination. Eleventh edition. 2005 Churchill Livingstone, Edinburgh
5. Department of Health. Good Practice in Consent Implementation Guide: Consent to Examination or Treatment. 2001 The Stationery Office, London.
6. **Hurley KJ**. OSCE and Clinical Skills Handbook. 2005 Saunders Elsevier, Ontario.
7. **Shah N** Taking a history: introduction and the presenting complaint. Student BMJ 2005. 13, September, 309-352.