

An Unusual Cause of School Refusal in a Child

A 7-year-old boy was referred to the Child Guidance Clinic at the Department of Pediatrics, Medical College, Calicut for school refusal. The problem started six months prior to consultation when he started passing urine frequently, while sitting in the class. He also developed nocturnal enuresis. The classmates, because of the smell of urine, ridiculed the child and he refused to go to school. He had previously attained full bladder control both day and night. There was no history of polyuria, polydipsia or pain during micturition.

He was born of non-consanguineous parents and had 4 siblings. There was no past history of seizures and no family history of epilepsy or mental retardation. The ante natal, natal and postnatal history and developmental milestones were normal. Child had below average academic performance.

Physical examination was within normal limits. Mental status examination was unremarkable except that he was sad because he was laughed at by his friends. Routine blood and urine examination results were within normal limits. Urine culture was sterile. Abdominal ultrasound examination was normal.

Possibility of an emotional disorder was thought of. The child and the parents were counselled regarding behavior therapy and he was started on Imipramine 1 mg/Kg single bedtime dose.

There was no relief of symptoms. During one of the follow up visits the child had an episode of vacant stare associated with incontinence. There were no twitching movements of the face or extremities and no loss of tone. Then the mother said that every

time he passed urine he had the same facial expression, which she attributed to the child's embarrassment.

The possibility of absence seizures was considered and the child was referred to the Department of Neurology. The EEG was abnormal and suggestive of atypical absence seizures. The child was put on sodium valproate and the symptoms remitted completely.

In a typical simple absence episode the patient abruptly loses consciousness, ongoing activity ceases without significant alteration in postural tone and the patient's eyes stare vacantly straight ahead or roll upwards(1). Atypical (complex) absence seizures are characterized by absence attacks associated with motor components consisting of myoclonic movements of the face or extremities and occasionally loss of body tone(1,2). They are associated with atypical EEG spike and wave discharges at the rate of 2-2.5/sec.(2). Urinary incontinence can occur in association with complex absence seizures(1,3). Urinary incontinence was reported to be one of the features distinguishing epileptic and non-epileptic events in children with staring spells(4).

The other causes of daytime incontinence in a child are urinary tract infections, pediatric unstable bladder (uninhibited bladder, bladder spasms), detrusor sphincter dyssynergia, infrequent voiding, giggle incontinence and Hinman syndrome(2).

The case is reported to stress the importance of detailed history taking and also to emphasize that organic causes should be considered and ruled out in any child presenting with daytime incontinence.

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Child Abuse - Where do we Stand Today?

A 5-year-old boy from a well- to-do family was brought by his father and stepmother with fracture right tibia, severe malnutrition, multiple abrasions, bruises, scars, hemiparesis, psychomotor retardation and old fractures in both ulnas and right humerus. A convincing explanation regarding the mechanism of injuries was not forthcoming. Skeletal survey, bone scan and MRI showed 15 fractures involving ribs, metacarpals, mandible, ulnas, right humerus and right tibia of varying ages and old subdural hematomas. Brittle bones disease and neuropathy were excluded by appropriate investigations. The child showed remarkable improvement in nutrition and psychomotor status when shifted to his grandparents' house on our advice. A medicolegal report and involvement of social organizations yielded no action and he again deteriorated when he was reallocated back to his parents four months later. It required the intervention of the court and human rights organizations to grant custody of the child to the parents of the (deceased) biological mother after which he is doing well.

The legal position of abused children in our

country is ambiguous. The cases that reach hospital represent the very tip of the iceberg. A pediatrician's role in the management of such cases is also not clearly defined and remarkable commitment is required to ensure that the child receives the necessary protection and support(1). Social organizations are also at a loss to deal with such situations without legal backing.

The CANCL group of the Indian Academy of Pediatrics is a positive step towards addressing the problems of these unfortunate victims of household violence(2). It would be appropriate if clear guidelines are provided to the pediatrician and other agencies such as police and social organizations (through enactment of legislation) in the management of suspected /confirmed cases of child abuse.

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