Commentary on Somatoform Illness and Patient Characteristics

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Children with somatoform illness present a real diagnostic and management puzzle for the pediatric hospitalist. These children are a source of diagnostic confusion, often leading to unnecessary hospitalization, extensive testing, and frustration on the part of caretakers and providers. The psychiatric underpinnings of their clinical presentation are frequently only discovered through a process of elimination, leading to a diagnosis of exclusion for these children presenting with somatoform disorders. In this issue of *Hospital Pediatrics*, Bujoreanu and colleagues[1] present their experience with this patient population in a large children's hospital. This work, in association with a previous discussion on this topic in this journal,[2] offers a way through this diagnostic challenge by identifying unifying characteristics that allow the hospitalists to "rule in" the psychiatric diagnosis early in presentation. This allows for the early intervention with the psychiatric consulting service, more informative dialogue with the parent and patient, and more goal-directed therapy. Importantly, because this condition copresents with other psychiatric diagnoses (anxiety and mood disorders commonly), psychiatric consultation may uncover these illnesses and allow for appropriate psychiatric based therapeutic interventions. Delayed or missing diagnosis of common psychiatric illness, frequent in the pediatric age group,[3] suggests a reluctance or inability to make these diagnoses in this age group. Through a ruling-in process as suggested by the authors and by recognizing the unifying demographic, psychological, and medical characteristics of these children, we may better provide for them. By contrast, one typically adopts a "ruling-out" process when working through an organic illness diagnosis. We think of the most life-threatening medical complication in the differential, rule that out, and work sequentially in this way to arrive at a correct diagnosis. These contrasting approaches are not mutually exclusive and may be complementary. By adopting a ruling-in approach with psychiatric illness, we can offer earlier identification of the correct diagnosis and offer earlier therapeutic intervention.

The authors' description of their population broadens our understanding of the demographics associated with the presentation of somatoform illness. They demonstrate that children from high socioeconomic status with characteristic temperament and coping styles are at risk to express somatoform illness. Importantly, a close temporal association with an inciting trauma was not uniformly present. These children were further unified by a high frequency of psychiatric illness in the immediate family and a previous diagnosis of psychiatric disorder (anxiety, mood). These children are at social risk by virtue of the large number of missed school days associated with this psychiatric disorder. With

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the enhanced recognition of these at risk children provided by the current work, the next step will be the development of integrated pathways of care, beginning with the early ruling in of a psychiatric diagnosis by the hospitalist, prompt early referral to the psychiatric service, coordinated care at discharge with the primary care provider, and engagement with outpatient behavioral mental health services. Increased sensitivity to the "psycho" component of psychosomatic illness presentations will limit the overuse of valuable medical resources by eliminating the step-wise ruling-out process so prevalent in current medical thinking that promotes repetitive laboratory testing, complex imaging modalities, and unnecessary subspecialty consultation.

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