Mickey lies still for an X-Ray at Princess Margaret Hospital for Children.

TAKING THE FEAR OUT OF INVESTIGATIONS

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In 1970 a medical student walked out of an examination room in a Radiology Department of a large teaching hospital saying, "I think that is barbaric, holding down a screaming child to have a bladder x-ray". At the time I thought she was over-reacting. After all, the child needed to have an x-ray examination of the bladder (MCU) and a kidney x-ray (IVP) to assess whether there were any organic abnormalities predisposing her two urinary infections with possible renal damage.

Some time later a mother returned to her referring paediatrician with a very distorted account of what had happened to her three year old daughter undergoing an x-ray examination of the bladder and kidneys.

Urinary tract infection is the most common renal disease in childhood and may occasionally lead to chronic renal disease.

It is current practice to undertake investigation of the bladder and the kidneys in children under five who are found to have a bacteriologically proven urinary tract infection. In our experience, some abnormality is found in 30-40% of patients and significant abnormality in 20%.

The bladder examination (micturating cystourethrogram) is performed by placing the child on an x-ray table. A skilled nursing sister places a small sterile catheter into the urethra using local anaesthetic jelly. A sample of urine is taken for pathological examination. Radiographic contrast is introduced and pictures are taken of the bladder whilst the child voids. Special film is used and the number of exposures are kept to a minimum to keep radiation exposure to an absolute minimum.

The kidney x-ray (intravenous pyelogram) is performed with the child on an x-ray table and a series of films of the kidneys and draining system are taken after injection of a special radio-opaque contrast.

The problem we faced was how to make this experience the least unpleasant for the child and the least distressing for concerned and worried parents.

The first requirement is that the staff must be technically competent so that an intravenous injection, even into a small struggling infant, should ideally be successful on the first attempt and technical staff must be skilled in providing high quality x-ray pictures of the procedure. So the most experienced and competent staff should handle the most difficult and smaller children.

The staff must be experienced with handling children, be able to talk to children and be patient.

However, this is not enough. Sometimes a child will present for an x-ray of the bladder and kidneys thinking that the experience will be the same as having an arm or a chest x-rayed.

To overcome this communication problem, we have prepared a number of small pamphlets explaining in language that children and parents can understand what will be involved in the procedure. In the introduction we state "We hope that Mum and Dad will read it and then, if necessary explain to their child in their own way". The front of the pamphlet has a photograph of Mickey Mouse being x-rayed on one of our x-ray tables and in our waiting room the walls have a series of pictures of Mickey Mouse having an x-ray in each of our investigation rooms.

When the parent and child arrives, there is an opportunity to talk to a trained member of staff about their concerns and ask any questions that they may have.

Having parents present in the examination room while the child

undergoes the examination used to be banned on the premiss that the child would misbehave if the parent was present and that the staff would become very nervous in the presence of parents and be less successful in performing an intravenous injection.

We have found that many children are much better with their parent present in the examination room and the parent then has a clear picture of what is happening to his or her child.

I have adopted the policy of talking to the parent, most usually the mother, prior to the examination saying "we usually find it easier for you to bring your child to the examination room and then wait in the waiting room. However, if you think that your child would be happier and you wish to be present in the room, then by all means come in".

Some parents do not wish to be present in the room as some feel uncomfortable seeing their child having an injection.

We have found that it is possible to negotiate with a child explaining that it is essential that they do lie still to enable us to take the x-ray photographs and prior to doing anything to the child, we explain exactly what we are about to do. For example, prior to giving an injection we explain that this will sting a little, just like a mosquito bite. Recently a little girl looked up at me and said "I suppose you will tell me that it won't hurt, Doctors always lie"!

Putting the above approach to performing procedures on children in our Radiology Department has resulted in fewer frightened children and grateful parents who understand what is happening to their child.

Of course not all children will lie quietly on an x-ray table while they are given an injection. Then it is essential to have very competent staff to obtain the required examination in the minimum time.

The value of this approach has been underlined by the number of parents who have come and thanked us and even brought gifts for the staff. Some, when the child is attending for the first examination and others because their child had had an unpleasant experience previously.

We are fortunate in our department that we have a combination of technical competence and caring people concerned about children undergoing investigations and who seek to reassure concerned parents.