CASE REPORTS

The hazards of using a child as an interpreter

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Keywords: *grief reaction; pervasive refusal; post-traumatic stress disorder*

SUMMARY

When a language barrier prevents communication with immigrant parents, there may be a temptation to use a bilingual child as an interpreter. We report a possible hazard.

CASE HISTORY

A Moslem Asian couple (double first cousins) had a male child who died aged 8 days. Post-mortem examination showed subdural haemorrhage, kernicterus, hydrocephalus and renal glial microcysts. They then had a healthy girl and four boys, the last of whom also had multiple congenital abnormalities. He had dysmorphic facies, hydrocephalus, poor feeding, hypotonia and a single dysplastic kidney. He spent much of his life in hospital and because of his severe handicap required nasogastric feeding.

The parents' command of the English language was poor. Their daughter (the subject of this report) interpreted for the medical staff. She was aged 10 years at the time and she became increasingly involved in the care of the baby. He deteriorated and died of renal failure at the age of 13 months.

Three months before her brother's death, she developed headaches, anorexia and weight loss. One month after his death, the anorexia led to severe lethargy and she was admitted to her local hospital. Her weight had fallen to 25.5 kg (less than 3rd centile), her height being 152 cm (on the 90th centile).

Full blood count, electrolytes, liver function tests, thyroid function, cerebro-spinal fluid, chest radiograph and brain computerized tomography were normal. She completely refused food and began to violently resist nasogastric feeding. Child psychiatric help was offered, but the family discharged her from hospital against medical advice. They tried unsuccessfully to feed her orally and nasogastrically at home but she continued to lose weight.

Two weeks later she was admitted to Booth Hall Children's Hospital. Child psychiatry consultation suggested an abnormal grief reaction. She continued to deteriorate and stopped speaking and walking. However, she remained strong enough to violently resist attempts at nasogastric feeding. Sedation during feeding was unhelpful, and a trial of antidepressant medication led to no improvement. She was transferred to the child psychiatry ward, where her management remained extremely difficult. With parental consent, nasogastric feeding was undertaken. Individual and family therapy was undertaken and the help of an Asian child psychiatrist experienced in cross-cultural issues was obtained. The family engaged in the treatment while simultaneously attending a Moslem priest. The child started to recover 3 months after admission, and was able to eat without tube feeding after 6 months. She was discharged after 8 months and 1 year later she weighed 34 kg (above the 3rd centile), communicated well and returned to school.

The family's preoccupations and the grieving process in other family members have also changed. For the first time, the child's mother is able to talk freely about her son's death and her grief for him. Previously, the girl's severe illness had so preoccupied the family that thinking about the son's death had been virtually impossible.

DISCUSSION

The diagnosis was felt to lie in the broad category of post-traumatic stress reaction. Anorexia nervosa was excluded because there was no altered body image, and no focus on diet. The best descriptive label for her illness was felt to be 'pervasive refusal syndrome' as described recently in four children by Lask and colleagues[1]. These were girls who had similar symptoms of equal severity. However, this case is exceptional in its aetiology. Unlike the cases reported by Lask, there was no suggestion of sexual abuse. The trigger in this case was thought to be the very close involvement that this young child had in the care of her dying younger brother, including her being used as interpreter between her family and the medical staff. The illness may, therefore, also be described as an abnormal grief reaction, and itself led to a delayed grief reaction in the family.

Siblings of sick children are known to be affected in different ways. In older children, girls tend to take a more active role in the care of their sick siblings[2]. This has been thought of as a source of comfort and protection. However, the case we have reported indicates the potential danger of involving children beyond the scope of their stage of development.

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REFERENCES

1 Lask B, Britten C, Kroll L, Magagna J, Tranter M. Children with pervasive refusal. *Arch Dis Child* 1991;**66**:866–9

2 Lobato D, Faust D, Spirito A. Examining the effects of chronic disease on children's sibling relationships. *J Pediatr Psych* 1988;**13**:389–407

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Endophthalmitis after routine intra-ocular surgery in an asplenic patient

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A 72-year-old asplenic man developed an acute early pneumococcal endophthalmitis after a routine endocapsular cataract extraction with poor final visual outcome. It is recognized that splenectomy increases the risk and severity of pneumococcal infections. Our patient had not received pneumococcal vaccination or been prescribed prophylactic antibiotics since his splenectomy or at the time of surgery. Failure of these measures to occur may have affected visual outome.

CASE HISTORY

A 72-year-old man underwent a routine cataract extraction and posterior lens implant for visual rehabilitation. Twenty years before he had undergone a staging splenectomy for Hodgkin's disease and has been free of recurrence since then. On the third post-operative day, he developed an early post-operative pneumococcal endophthalmitis. Despite vitrectomy with intra-vitreal antibiotics and high dose intravenous penicillin, the eye became blind. His blood film showed Howell–Jolly bodies in keeping with hyposplenism. His white blood cell count and differential, complement levels, lymphocytes subtypes and immunoglobulins, apart from a slightly low IgM, which is typical of hyposplenism, were all found to be normal.

After haematological advice the patient has received pneumococcal vaccine and has been commenced on lifelong daily penicillin V to prevent further pneumococcal infection.

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COMMENT

Pneumococci are Gram positive encapsulated diplococci which characteristically evoke suppurative exudative reactions. Pneumococci produce no toxins and virulence depends on invasiveness. One of the factors affecting host response to an encapsulated organism is the spleen[1]. Endophthalmitis is a devastating but fortunately rare complication of cataract surgery with an incidence of less than 0.1%[2]. Pneumococcus is a relatively rare organism with most early post-operative endophthalmitis being caused by *Staphylococcus epidermidis, Staphylococcus aureus* and proteus.

Asplenic patients have a 12-fold increase in the rate of infection compared to those with normal spleens and if the splenectomy follows malignant disease, the increased risk is 25-fold[3]. Severe localized and systemic pneumococcal infection can occur at any time following splenectomy for Hodgkin's disease[4]. This risk is substantially reduced by pneumococcal vaccination and prophylactic penicillin[5]. Current haematological advice favours pneumococcal vaccination and lifelong daily penicillin to all asplenic patients[6]. It would seem logical that splenectomized patients are at a higher risk of post-operative pneumococcal endophthalmitis. Endogenous pneumococcal endophthalmitis has been reported in three separate cases in asplenic patients but this followed pneumococcal bacteraemia[7,8].

The clinical course of endophthalmitis depends on the interplay between host defences and the virulence of the pathogen. In a recent review of infective endophthalmitis following vitreoretinal surgery potential medical risk factors for sepsis were identified in 5 of 11 cases and supplementary antibiotic prophylaxis was recommended[9].

When asplenic patients undergo intra-ocular surgery, it would be advisable to administer an appropriate peri-operative subconjunctival antibiotic and continue routine systemic antibiotic prophylaxis. Penicillin G or a second generation cephalosporin such as cefuroxime would provide good prophylaxis against pneumococcal infection. Ophthalmologists should be aware that the splenic status of a patient is one of the factors affecting host-response to pathogens, particularly encapsulated bacteria and, thus, risk of endophthalmitis.

REFERENCES

1 Hosea SW. Role of the spleen in pneumococcal infections. *Lymphology* 1983;**16**:115–20

2 Rosner F, Zarrabi MH. Late infections following splenectomy in Hodgkin's disease. *Cancer Invest* 1983;**1**:57–65