PedsCases Podcast Scripts

This is a text version of a podcast from Pedscases.com on the "**International Adoption**." These podcasts are designed to give medical students an overview of key topics in pediatrics. The audio versions are accessible on iTunes or at www.pedcases.com/podcasts.

International Adoption

Developed by Jenny Shi and Dr. Cecilia Baxter for PedsCases.com.
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Introduction

Hi, my name is Jenny Shi and I am a medical student at the University of Alberta Faculty of Medicine and Dentistry. This podcast has been reviewed by Dr. Cecilia Baxter, a pediatrician at the Edmonton Adoption Clinic at the Royal Alexandra Hospital in Edmonton, Alberta. This podcast will address international adoption medicine, with the main objective to provide a brief overview of the different stages in which pediatricians may become involved. We will be going over the goals and general content of each of the following visits:

- Pre-adoption medical consultation visit
- Post-adoption medical consultation visit
- Long term follow-up

Each year, Canadian families adopt approximately 2,000 children from China, Haiti, Ethiopia, and countries all over the world. Because of the unique backgrounds these children come from, they often have special health care needs and concerns, ranging from growth and developmental delay, attachment disorders, malnutrition, prenatal and postnatal exposure to toxins and drugs, and exposure to infectious diseases. As a result, international adoption medicine has emerged as a relatively new field of pediatric medicine to address the needs of these adoptees.

Pre-Adoption Medical Consultation:

Returning to our case:
Additional documentation states the child was found abandoned at one day of age. Up to date medical information and photos are included. They tell you the child at 15 months weighs 8.3 kg (11.1 percentile on the WHO growth chart), height is 71 cm (1.1 percentile) and head circumference is 45cm (34.5 percentile). Physical exam is listed as normal. The child has been vaccinated according to the Chinese schedule. Labs are only significant for a positive HBsAb, (HBsAg negative) and a mild microcytic anemia. That couple asks " So, should we adopt her?"

The main purpose of the pre-adoption visit is to provide the prospective parents with a risk assessment of the international adoptive child, as well as to provide referrals to

travel clinics for the adoptive parents and extended family members who would be in contact with the child.

Assessing risk is inherently challenging because of the inability to physically examine the prospective child. Adoption agencies may supply the physician and family with brief videos or photos, possibly accompanied by basic information on growth parameters and developmental milestones. However, these files should be read with caution as local medical terminology may often be misleading, and data may be incomplete or incorrect. If available, the following information should be shared and discussed with the prospective adoptive families: endemic risks in the country of origin, family history of mental illness or mental retardation, antenatal drug or alcohol exposure, estimated age of the child, prematurity, birth trauma, low birth weight, history of abuse/neglect, prolonged or recurrent hospitalization or institutionalization, malnutrition, developmental delay, and any other medical diagnoses or issues.

Institutionalization in an orphanage presents unique or enhanced risks, including lack of or inappropriate medical care, linear growth delays, global developmental delays, and possible lower IQ. However, with careful attention and stimulation from the adoptive parents, several of these deficits can be reversed.

At this visit, families may also ask about health outcomes of internationally adopted children. Some recent studies show a moderately increased risk of attention deficit hyperactivity disorder and increased incidence of executive functioning and sensory processing difficulties in adopted children compared to children who were not adopted. At times, a family may also directly ask whether or not they should adopt the child. Instead of saying “yes” or “no”, it’s important to make the parents aware that (as quoted from the Committee to Advise on Tropical Medicine and Travel’s Statement on International Adoption) “each internationally adopted child is a special-needs child, no child is ‘normal’ and that the process should focus on risk assessment”.

Lastly, it is important to emphasize to the family that this preliminary risk assessment is limited because the source of information is often unreliable.

Thus, in our case, we would advise the couple that based on the limited information we have, the adoption of this child is likely low to moderate risk.

Post Adoption Medical Assessment

4 months later, Julia and Rob return with their new baby girl, whom they’ve named Tina. Her measurements at this appointment are a weight of 8.5 kg (4.5 percentile), height 77 cm (5.5 percentile), head circumference 46cm (38.2 percentile), and normal physical exam. On history, you also find that she has a mild global developmental delay. Her labs come back normal, except for giardia in her stools, and mild iron deficiency anemia. A Mantoux test is positive. What do you do with these results? What else should you address at this appointment?

Your first encounter with the child and her new family should occur within two to three week of her arrival in Canada. The purpose of this visit will be to review all available medical and vaccination records, do a complete physical exam, diagnose and manage acute medical concerns, do screening tests, growth and developmental assessments, and review adjustment and attachment issues.

Important questions to ask on history include signs of disordered or insecure attachment, such as poor eye contact, difficulty initiating or accepting social and physical contact, indiscriminate responsiveness to different people, and hyperactivity. Previously institutionalized children may also display repetitive or self-soothing behaviors. Developmental progress and concerns should also be recorded. Reassure the parents that with time and an enriching environment, many of these issues can self-correct.

Because overseas health assessments are not standardized, the standard of care is to screen all children for the following diseases, regardless if testing has already been performed in their home country:

- First are the infectious diseases: watch out for the common ones: Hepatitis, B, hep A, TB, and parasitic infections in the stool. Also order serology for strongyloides, schistosoma, HIV, Hepatitis C, and syphilis. The TB, HIV, hep B/C tests are repeated 6 months later because of potential false negatives if the child was infected just prior to adoption.
- Next are non-infectious diseases: common ones are anemia and thyroid dysfunction. You can also order CBC with differential for parasitic infectious causing eosinophilia, electrolytes/Cr/Urea for renal failure, AST for hepatitis, rickets screen with Ca/phosphate/ALP, urinalysis, lead level with zinc protoporphyrin
- Lastly, hearing and vision tests are important as well.
- Additional tests can be ordered if diseases are known to be endemic in certain birth countries. These include malaria testing, Hgb electrophoresis for thalassemia, sickle cell prep, and G6PD deficiency screening.

The physical exam should focus on detecting dysmorphisms that might indicate antenatal drug or alcohol exposure, syndromes, abnormal head shape, malnutrition, rickets, scabies or lice.

The next step is to determine a vaccination plan for the child. If there is no immunization record or if it is unreliable, the current recommendation is to repeat all immunizations. Risks of repeating vaccines are minimal, including local pain, swelling, erythema, irritability.

Anticipatory advice is also valuable at this initial appointment, since many adoptive parents find themselves in the unique challenge of suddenly becoming new parents “overnight”. One common cause of stress can be sleep disturbances as the child adjusts to their new sleeping environment. Sleep training, if necessary, should be

withheld until the child feels safe and develops a secure relationship with his or her new family. Parents may also face feeding issues, as many children are unaccustomed to western formulas, bottles or have oral-motor disco ordination. Feeding strategies can be offered, but more important are encouragement and reassurance that the situation should improve naturally over time. Cultural identity issues should also be discussed and revisited at later appointments. Like with other regular pediatric check-ups, other important topics to discuss include: nutrition, childproofing, avoidance of smoke exposure, childcare, car seat safety, dental care, discipline, and so on. Don't forget to address and educate parents on signs and symptoms of post adoption depression, which can occur with similar rates to postpartum depression.

Back to our case: Tina was sent to the TB clinic after a negative chest x ray and an interferon-gamma release assay confirmed latent TB infection. As a result, Tina was treated with 9 months of INH and B6, her giardia was treated with flagyl, and her mild iron deficiency anemia treated with iron for 3 months. Additionally, a vaccination plan was created. Although the last few months have been challenging for Julia and Rob, they have no other concerns and are overjoyed by the new addition to their family and are grateful for your care.

Long-term Follow-up

After the initial assessment, at least 3 follow-up visits are recommended: 2-3 months post-adoption, 6 months, and 1 year. At each of these appointments, it is important to review any ongoing or new medical problems, carefully assess and document growth and developmental milestones, review attachment issues, and provide timely referrals to community resources as needed. Also remember to repeat serology for HIV, TB, Hepatitis B, C, at the 6-month visit. After the 1-year visit, parents are advised to return to their primary care provider for regular medical follow-up. However, as adoption is a lifelong process for families, the door is open for any ongoing or new concerns, such as those that may arise when the child transitions into school.

Conclusion:

Despite the many medical, financial, and emotional challenges that come with the international adoption process, the overwhelming majority of families find the experience to be positive and rewarding, with these children bringing incredible joy, love, and fulfillment into their lives. Many families even go on to welcome more internationally or locally adopted children into their homes and recommend the option to other prospective parents.

This concludes our podcast. Here are the take home points:

- The goals of an international adoption clinic are to offer pre-adoption counseling for families and provide medical assessment of the adopted child after arrival in Canada
- The purpose of the pre-adoption visit is to provide risk assessment and refer family members to a travel clinic. Resist any pressure to tell parents whether or not they should adopt the child, instead emphasizing that each internationally

adopted child is a special-needs child, no child is 'normal' and that the process should focus on giving the child a high to low risk estimate.

- The first post-adoption visit should occur within 2-3 weeks of arrival. Its purpose is to diagnose and manage acute medical problems, do screening tests, and assess development, growth and attachment.
- The next recommended visits are at 3 months, 6 months, and 1 year. The purpose of these visits is to review medical problems, assess growth, development and attachment, and provide timely referrals to community services.
- Lastly, it is important to remember that adoption is a lifelong journey. Though many challenges come with the process, families often find it is one of the most rewarding things they have ever done.

References

Committee to Advise on Tropical Medicine and Travel. Statement on International Adoption. Canada Communicable Disease Report 2010; 36; ACS-15.

Miller LC. International adoption: infectious diseases issues. Clin Infect Dis 2005; 40:286-93.

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