Crying i

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Etiology | Evaluat

All infants and young c they have to express a need. Thus, r aper), or separation, and it ceases when the ng is normal and tends to lessen in dura at persists after attempts to address rc ation to the child's baseline should be inv

Etiology of Crying in Children

Cause of crying is

- Organic in < 5%
- Functional in 95%

A common nonorganic cause of crying is colic. Colic is excessive crying that occurs in infants ≤ 4 months of age that has no identifiable organic cause and that occurs at least 3 hours/day > 3 days/week for > 3 weeks.

Organic

Organic causes of crying, although rare, must always be considered. Causes to consider are classified as cardiac, gastrointestinal, infectious, and traumatic (see table Some Causes of Crying in Children). Of these, potential life threats include heart failure, intussusception, volvulus, meningitis (see also Bacterial Meningitis in Infants Over 3 Months of Age and Neonatal Bacterial Meningitis), and injuries, particularly intracranial bleeding due to head trauma.

TABLE

Some Causes of Crying in Children

Cause		
Cardiac		
Coarctation of the aorta		
Heart failure	Diaphoresis Poor feeding Third heart sound (S3) gallop	ECG Echocardiography
Supraventricular tachycardia	Tachypnea Cough Diaphoresis Poor feeding Heart rate > 180 beats/minute (usually 220–280 beats/minute in infants; 180–220 beats/minute in older children)	Chest radiograph ECG
Gastrointestinal		
Constipation	Anal tears or fissures History of decreased stool frequency and hard pellet stools Distended abdomen	History and physical examination

Gastroenteritis	Hyperactive bowel sounds Vomiting and loose, frequent stools	History and physical examination
Gastroesophageal reflux		edance probe
Intussusception		
Cow's milk protein intolerance (milk protein allergy)	Poor feeding Growth and weight faltering (formerly known as failure to thrive) Rash	v's milk protein from diet (eg, using hydrolyzed formula or removing milk protein from the mother's diet if breastfeeding/chestfeeding)
Volvulus	Bilious vomiting Tender, distended abdomen Bloody stools Absent bowel sounds	Abdominal radiograph Barium enema
Incarcerated hernia	Tender, erythematous mass in groin	History and physical examination
Infection		
Meningitis	Fever Inconsolability, irritability Lethargy Bulging anterior fontanelle in infants (see	Lumbar puncture for cerebrospinal fluid

	Neonatal Bacterial Meningitis)	testing
	Nuchal rigidity (meningismus) in older children (see Bacterial	
Otitis media		xamination
Respiratory infecti (bronchiolitis, pneumonia)	crackles, or decreased breath sounds on auscultation	
Urinary tract infection (UTI)	Fever Possible vomiting	Urinalysis and culture
Trauma		
Corneal abrasion	Crying with no other symptoms	Fluorescein test
Fracture (eg, due to child abuse)	Area of swelling and/or ecchymoses Favoring of a limb	Skeletal survey radiographs to check for current and old fractures
Hair tourniquet	Swollen tip of a toe, finger, or penis with hair wrapped around the appendage proximal to the swelling	History and physical examination
Head trauma with intracranial bleeding	Inconsolable, high-pitched cry Localized swelling on skull with underlying deformity	Head CT

Abusive head trauma	Inconsolable, high-pitched cry Lethargy	Head CT Retinal examination Skeletal survey ation for child
Other		
Testicular torsion		nuclear scanning
Vaccine reaction		xamination

Evaluation of C

History

History of present illn mpts to console, and frequency or uniqueness of episodes. Parents should be asked about associated events or conditions, including recent immunizations, trauma (eg, falls), interaction with a sibling, infections, substance use, and relationship of crying with feedings and bowel movements.

Review of systems is focused on symptoms of causative disorders, including constipation, diarrhea, vomiting, arching of back, explosive stools, and bloody stools (gastrointestinal disorders); fever, cough, wheezing, nasal congestion, and difficulty breathing (respiratory infection); and apparent pain (trauma).

Past medical history should note previous episodes of crying and conditions that can potentially predispose to crying (eg, history of heart disease, developmental delay).

Physical examination

Examination begins with a review of vital signs, particularly for fever and tachypnea, as well as a review of growth parameters. Initial observation assesses the infant or child for signs of lethargy or distress and notes how the parents are interacting with the child.

The infant or child is undressed and observed for signs of respiratory distress (eg, superclavicular and subcostal retractions, cyanosis). The entire body surface is inspected for swelling, bruising, and abrasions.

Auscultatory examination is focused on signs of respiratory infection (eg, wheezing, crackles, decreased breath sounds) and cardiac compromise (eg, tachycardia, gallop, holosystolic murmur, systolic click). The abdomen is palpated for signs of tenderness. The diaper is removed for examination of the genitals and anus to look for signs of testicular torsion (eg, red-ecchymotic scrotum, pain on palpation), hair tourniquet on the penis, inguinal hernia (eg, swelling in the inguinal region or scrotum), anal fissures, and trauma.

Extremities are examined for signs of fracture (eg, swelling, erythema, tenderness, pain with passive motion). Fingers and toes are checked for hair tourniquets.

The ears are examined for signs of trauma (eg, blood in the canal or behind the tympanic membrane) or infection (eg, red, bulging tympanic membrane). The corneas are stained with fluorescein and examined with a blue l with an ophthalmoscope for si amination by an ophthalmologist is adv abrasions. The skull is gently palpated for s

Red flags

The following findings

- Respiratory distr
- Bruising and abr
- Extreme irritabil
- Fever and incons
- Fever in an infan

Interpretation of

A high index of suspici n important variable. When concer conclusive findings because the parents may be reacting subconsciously to subtle but significant changes. Conversely, a very low level of parental concern, particularly if there is lack of parental interaction with the infant or child, can indicate a bonding problem or an inability to assess and manage the child's needs. Inconsistency of the history and the child's clinical presentation should raise concerns about abuse.

It is helpful to distinguish the general area of concern. For example, with fever, the most likely etiology is infectious; respiratory distress without fever indicates possible cardiac etiology or pain. Abnormalities in stool history or abdominal pain during examination is consistent with a gastrointestinal etiology. Specific findings often suggest certain causes (see table Some Causes of Crying).

The time frame is also helpful. Crying that has been intermittent over a number of days is of less concern than sudden, constant crying. Whether the cry is exclusive to a time of day or night is helpful. For example, recent onset of crying at night in an otherwise happy, healthy infant or child may be consistent with separation anxiety or sleep association issues.

The character of the cry is also revealing. Parents frequently can distinguish a cry that is painful in character from a frantic or scared cry. It is also important to determine the level of acuity. An inconsolable infant or child is of more concern than an infant or child who is well-appearing and consolable in the office.

Testing

Testing is targeted at the suspected cause (see table Some Causes of Crying) and particular attention is paid to potential life threats, unless the history and physical examination are sufficient for diagnosis. When there are few or no specific clinical findings and no testing is immediately indicated, close follow-up and reevaluation are appropriate.

Treatment of Crying in Children

The underlying organic disorder should be treated. Support and encouragement are important for parents when the infant or child has no apparent underlying disorder. Swaddling an infant in the first month of life can be he uration of crying.

It is also valuable to en k from a crying baby and put the infant or c parents and "giving permission" to take a b r support services to parents who seem ove

Key Points

- Crying is part irst 3 months.
- Excessive cry ic.
- Less than 5%
- Parents may

Drugs Mentioned in This Article