

Care of the Foreign-born Child

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Definition and Assessment

Definition

The foreign-born child has typically been

- Abandoned
- Malnourished
- Born to impoverished mothers with little access to health care
- Institutionalized
- Emotionally and developmentally delayed
- Female >1 year-of-age¹

Assessment

- Pre-adoption consultation²
 - Review available history, growth and development, photographs and videos of the foreign born child in his natural environment.
 - Define parental expectations.
 - Discuss travel health issues for family and child, including immunization safeguards for prevention of illness and topical and oral products for the foreign born child, i.e., antihistamines, antipyretics, formulas, etc.
 - Schedule follow-up visit prior to travel if family desires to review any “new information.”

- Post-adoption assessment
 - Acute or unstable condition – evaluate and treat as needed
 - Stable condition – follow post-arrival guideline, below

Care of the Foreign-born Child Post-arrival Guideline

Visit 1 (Within 14 days post-arrival)

- Meet with family; seek any new information or “new family” experiences.
- Perform complete history and physical examination including growth parameters and baseline developmental status.
- Draw baseline labs: CBC, BMP, Lead, HIV, RPR, Hepatitis A, B, & C serology, T4, TSH.
- Consider liver function tests and urinalysis; obtain stool studies for ova and parasites and routine culture for salmonella, shigella, E. coli, and *Giardia*.
- Give “first set of vaccines” excluding live virus (MMR, Varicella) vaccines.
 - This will be age dependent but most likely DTaP #1, IPV #1, Hib #1, and Prevnar™ #1.
 - Live virus vaccines will be given at a subsequent visit pending laboratory evaluation of the patient’s immune system.
 - Hepatitis B will be postponed pending serology results.
- Place PPD and read within 2-3 days.
- Schedule baseline audiology and ophthalmology exams.
- Schedule dental examination as indicated by age or clinical exam.
- Schedule any necessary subspecialty appointments.
 - ENT – cleft lip/palate
 - Cardiology – known congenital heart disease or physical exam findings
 - Orthopedics – bony deformities or limb length discrepancies
 - Developmental Pediatrics/Genetics – Fetal Alcohol Syndrome, Down Syndrome, etc.

Visit 2 (6 weeks after Visit 1)

- Inquire about family transition, concerns, and behaviors.
- Plot interval growth; conduct thorough history and physical exam.
- Reassess developmental progress.
- Review laboratory findings, treat as indicated, and follow-up on referrals from Visit 1.
- Immunize with live virus vaccines if immune status competent (MMR, Varicella).
- Initiate Hepatitis A and Hepatitis B series if serology indicates.
- Assess for cognitive/emotional/behavioral/attachment issues and follow or refer.

Visit 3 (12 to 14 weeks after Visit 1)

- Inquire about family transition, concerns, and behaviors.
- Plot interval growth; conduct thorough history and physical exam.
- Reassess developmental progress.
- Update vaccines.
- Assess for cognitive/emotional/behavioral/attachment issues and follow or refer.

Visit 4 (20 to 24 weeks after Visit 1)

- Inquire about family transition, concerns and behaviors.
- Plot interval growth; conduct thorough history and physical exam.
- Reassess developmental progress.
- Update vaccines.

- Assess for cognitive/emotional/behavioral/attachment issues and follow or refer.
- Follow-up on subspecialty recommendations as necessary.
- Continue to see every 3-6 months pending clinical response, growth and developmental progress, and patient's age at arrival until clinically and medically adjusted.

Diagnosis and Management of Medical Conditions Common in the Foreign-born Child

Infectious Diseases

- Tuberculosis³
 - Most common infectious disease in foreign-born children
 - Usually asymptomatic⁴
 - Each foreign-born child should be screened with a PPD despite having received BCG in birth country.
 - Each child with a positive PPD should receive a chest x-ray.
 - Each child with a positive PPD screen and negative chest x-ray should receive isoniazid (INH) and referral to infectious disease specialist; notify health department.
 - Each child with a positive PPD and positive chest x-ray should be referred promptly to an infectious disease and/or pulmonary specialist; notify health department.

Tuberculosis Screening: PPD⁵

<u>Induration</u>	<u>Result</u>	<u>Action</u>
<5mm	Negative	Repeat in 6-12 months
>5mm + known exposure	Positive	Chest x-ray
≥10mm	Positive	Chest x-ray

- Hepatitis A, B, and C
 - Hepatitis A often ubiquitous; screening unnecessary unless symptomatic
 - Hepatitis B
 - Endemic in every sending country
 - Usually asymptomatic
 - Screen with HBsAg, HBsAb, and core antibody.
 - If HBsAg negative, immunize child and retest in 6 months.
 - If HBsAg positive, obtain HBeAg, HBeAb, liver function tests, Hepatitis B viral load, and refer patient to infectious disease and/or GI specialist.
 - Hepatitis C⁶
 - True incidence unknown
 - Screen the foreign-born child at arrival and 6 months post-arrival with Hepatitis C antibody; qualitative PCR useful to confirm infection.
 - Immunize children with Hepatitis A and B vaccine.
 - Refer to GI if positive.
- Syphilis
 - Rare
 - Usually asymptomatic

- Screen with rapid plasma reagin (RPR).
- If positive screening test, or known past exposure, test with FTA-ABS or MHA-TP.
- Consider lumbar puncture and long bone films.
- Refer to infectious disease specialist if symptomatic or positive results.
- HIV - rare in the foreign-born child⁷

Intestinal Parasites

- Extraordinarily common in the foreign-born child
- Usually asymptomatic⁵
- Stool screening for ova and parasites, culture and *Giardia* antigen
- *Giardia* is most common.⁸
- Treatment based on organism identified, i.e., metronidazole

Infestations-Scabies and Lice

- Lower incidence than expected
- Treat with scabicide for index case and household contacts as per standard of care^{9,10}

Physical Anomalies

Refer to subspecialists as indicated.

- Cleft lip/palate
- Strabismus
- Limb defects
- Fetal Alcohol Syndrome

Growth Delay

- Most common initial problem identified as $\frac{2}{3}$ of foreign-born children fall more than 2 standard deviations from the mean on 1 or more growth parameters.¹¹⁻¹³
- Low weight-for-age, but height more greatly affected (psychosocial dwarfism)¹¹⁻¹³
- Rapid catch-up growth expected within 6-12 months of arrival on well-balanced diet; supplements seldom needed¹
- Follow growth trend every 6-8 weeks.
- If not making demonstrable gain after 6-12 months, evaluate for other medical/psychosocial conditions.

Developmental Delay

- Commonplace with 50%-90% of foreign-born children affected^{12,15,16}
- Developmental screening is necessary with each encounter with a goal of 3 screenings within first year of arrival.¹⁷
- May use ASQ (Ages and Stages Questionnaire), Denver II, or PEDS (Parents Evaluation of Developmental Status)
- Partially or completely reversible^{18,19}
- Accelerated "catch-up" development is common.^{18,19}
- May benefit from early intervention for physical therapy, occupational therapy, and/or speech therapy evaluations¹⁸
- May have implications for future learning and processing

Behavioral and Psychosocial Issues

For any of the behavioral and psychosocial issues, a foreign-born child may require mental health services, and/or cognitive behavioral therapy, and/or academic support for optimal outcome.

- Institutional behaviors
 - Rocking
 - Head banging
 - Biting
 - Nightmares/terrors
 - Feeding difficulties (hoarding food → food refusal)^{20, 21}
 - High pain threshold
 - Impulsivity
- Attachment issues²²
 - Healthy attachment
 - Discriminate parent from strangers
 - Balance dependence with emerging independence
 - Explore “new” environment and return to caregiver
 - Unhealthy attachment
 - Separation anxiety
 - Aggression
 - Passivity
 - Sensory integration issues
- Ethnic and cultural differences
 - Identity issues
 - Impaired executive functioning

References

This guideline was developed to improve health care access in Arkansas and to aid health care providers in making decisions about appropriate patient care. The needs of the individual patient, resources available, and limitations unique to the institution or type of practice may warrant variations.

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