.....SUMMARY.....

SUMMARY

FUO in children remains a difficult clinical problem because of the broad spectrum of possible underlying disorders. It calls for mobilization of all physician's own skills and the experits of colleagues as well as maintenance of an open mind to the patients complaints and observations.

The term FUO should be reserved for children with (1) documented fever of more than 1 week duration, (2) fever documented in hospital, and (3) no apparent diagnosis after an investigation of 1 week in hospital. In general practice FUO is simply defined as a child who presents with pyrexia alone, or with pyrexia in association with vomiting and or headache and or abdominal pain, for one of several different diagnosis can emerge from the initial undiagnosed state. It differs from classically defined FUO in that the illnesses are short and resolve early. Also the illnesses are common disorders, contrary to diagnostic spectra in ''hospital'' FUO which tend to list rare and serious diseases.

FUO in children can be divided into 4 groups on the basis of their underlying causes: 1- Lnfections,

2- Collagen-vascular, 3- Neoplasms and 4- Miscellaneous. These basic groups of diseases are the same as in adults, but the prominence of juvenile rheumatoid arthritis and the frequency and subtle presentations of regional enteritis are more apparent in the pediatric patient.

A well-performed history and physical examination accompanied by well-reviewed simple laboratory tests and careful reevaluation of the patient, are the real keys to correct diagnosis. Initially the doctor should make absolutely certain that there is in fact a sustained temperature. The history and physical examination must be aggressive, implying not only that they will be done carefully and thoroughly but that they will be repeated again and again.

When there are symptoms or signs other than chills, fever, malaise or weight loss (e.g. lethargy, disorientation, rash, dyspnoea, cough, cardiac murmurs, jaundice, lymphadenopathy, dysuria, arthritis or other joint manifestations, vomiting, diarrhoea), the initial investigation should be directed at those organ systems most likely to be the source of the FUO. In addition, it is often necessary to proceed with certain investigations in the absence of specific clues. Although such ''fishing

trips'' are intellectually unattractive, they are quite appropriate. These laboratory investigations should be performed in a graded yet expeditious manner, as outlined previously.

The use of antimicrobial agents, adrenal corticosteroids, or other anti-inflammatory agents either singly or together, without a specific working hypothesis is unwise and is apt to confuse rather than clarify the situation. Therapeutic trials of drugs, including antibiotics, are occasionally warranted when all reasonable investigation has failed to establish a diagnosis and the clinical picture is suggestive of a specific cause. It is justified in suspected cases of tuberculosis, acute rheumatic fever, or juvenile rheumatoid arthritis. When bacterial endocarditis is suspected on clinical grounds, it may be necessary to institute antibiotic therapy even though blood cultures have failed to reveal an organism.