



Fetal Alcohol Exposure: Time to Know, Time to Act

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Diagnosis

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Barbara Fitzgerald, MD, FRCPC, is a developmental pediatrician at the Children's and Women's Health Centre of British Columbia. She is a member of the Substance Exposure Resource Team and also coordinates a program to support the developmental assessment and diagnosis of inner city children in the Vancouver school system. At the request of the Adoption Society of B.C., she also provides consultation to parents hoping to adopt children locally and internationally. Her work has focused mainly on the care of children at risk for developmental challenges as a result of poverty, deprivation, abuse, and/or prenatal substance exposure. She has acted as an expert witness at trials related to the field of Fetal Alcohol Syndrome. She has been asked to speak extensively in the community about the need for understanding the challenges faced by high risk children and the need to advocate for supports

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Christine A. Loock, MD, FRCPC, is a developmental Pediatrician at Children's and Women's Health Centre of British Columbia and is a Medical Consultant for the BC provincial government on Fetal Alcohol Syndrome (FAS). Dr. Loock works extensively with children with neurodevelopmental disorders and birth defects including Fetal Alcohol Syndrome (FAS) and other craniofacial conditions. She is a coinvestigator on numerous research studies on FAS and other drug effects on children and young adults. Her credentials as an expert witness on FAS have been accepted in the Provincial and Supreme Courts of British Columbia. She is recognized by her peers as an expert in the field of FAS prevention in Canada and in 2000 was appointed by Ottawa to the Canadian Centre on Substance Abuse Board of Directors and to the National FAS Advisory Committee.

Why Make the Diagnosis ?

- Prevention of more children being born with FAS
- Diagnosis may help focus on understanding functional disabilities and thereby prevent secondary disabilities

Triggers for Assessment: Infancy

- History of prenatal exposure
- Non-specific presentation
- Fussy, colicky or sleepy
- Floppy
- Poor weight gain despite adequate calorie intake
- Poor suck
- Poor state regulation

Triggers for Assessment: Toddlers

- Speech and language delay
- Fine motor skill delay
- Decreased attention span
- Impulsivity
- Hyperactivity
- Poor short-term memory

(can't follow instructions)

Triggers for Assessment: Toddlers cont

- Sensory issues
 - easily overstimulated
 - bothered by noises, textures
- Difficulty with transitions
- Routine bound
- Social skills immaturity

Behaviour-how does it differ from young children who have “simple” ADHR or developmental delay

- More unpredictable
- Emotionally labile
- Good days/bad days
- Commonly used behaviour modification techniques don't work, or only work for short periods
- Cause and effect relationships not appreciated
- “good” behaviours are not generalized
- Rules are “parroted” but not internalized

Triggers for Referral: Early School age (K-3)

- Speech and language delay (appears to be resolving)
- Clumsy
- Hyperactive, impulsive, inattentive (?ADHD)
- Difficulties with phonics
- Difficulties with math
- Poor social skills
- Safety concerns/poor judgment
- Learning disabilities/intellectual disability

Triggers for Referral: Later School Age (Grades 4-7)

- More disruptive/inattentive behaviour
- Difficulty understanding consequences
- Don't get any work done without 1:1 attention
- Grades may drop
- School suspensions

Triggers for Referral: Later School Age (Grades 4-7) cont

- Oppositional behaviour, lying
- Emerging conduct problems/antisocial behaviour
- Depression
- Poor comprehension of social rules and expectations

Triggers for Referral: Adolescence

- Discouragement, low self-esteem
- School failure/dropout
- Conduct disorders/trouble with the law, faulty logic
- Lack of friends
- Inappropriate sexual behaviour
- Depression, other mental health issues
- Drug and alcohol use problems

Making the Diagnosis

Growth

Face

Brain

Alcohol

The Assessment Process: What to expect

Physician

1. Complete history of parental and teacher concerns
2. Physical exam growth, especially facial characteristics and neurological exam

The Assessment

Psychologist

1. Cognitive Skills Assessment
IQ. test (e.g. WISC III) looking at verbal problem solving abilities and non-verbal skills (visual perceptual, visual-spatial, visual motor) Memory function (auditory and visual) Graphomotor (pencil and paper) skills Attention/concentration executive functioning (reasoning, concept formation)

2 Academic (Achievement) Testing

reading

reading comprehension

written spelling arithmetic

3. Adaptive Functioning “the performance of the daily activities required for personal and social sufficiency”

- age related norms
- Defined by typical performance, not ability

Vineland Adaptive Behaviour Scales

1. Communication Domain

receptive language skills
expressive language skills
written language skills

2. Daily Living Skills Domain

personal living skills
domestic skills
community living skills

Vineland Adaptive Behaviour Scales cont

3 Socialization Skills Domain

interpersonal relationships
play and leisure time
coping skills

4 Motor Skills (only up to age 6)

gross motor skills
fine motor skills

Occupational Therapist

- Further assess fine motor
visual perceptual,
graphomotor skills
- Explore sensory issues

Speech and Language Pathologist

- Expressive/receptive language abilities
- Understanding of concepts
- Inferential and higher level language assessment

A Word About Language

- In the toddler years expressive (and receptive) language is delayed
- By early school age, it may appear to have caught up
- Receptive language skills, auditory processing, auditory memory may be problematic
- In the later years language can play an important role

These subtle and often unnoticed language deficits lead to:

- Misunderstood instructions
- Difficulty remembering instructions
- Misinterpretation of verbal and social cues
- **TROUBLE!!**

A Word About Attention Deficit Hyperactivity Disorder

- Attentional weakness, hyperactivity, impulsivity definitely occur in FASD but these are not always symptoms of isolated ADHD
- Other reasons for these symptoms must be explored and supported
- It is a myth that traditional medical therapies don't work in kids with both FASD and ADHD but they must be used in the context of a complete assessment, diagnostic and treatment process

Conclusions:

- FASDs present in different ways at different ages
- Sometimes the presenting behaviour is reflective of an underlying neurological problem that should be assessed and supported
- “front line” people (teachers, therapists, social workers, counsellors, caregivers) need to be aware of the varied presentations of FASD so that appropriate assessment and diagnostic services can be sought

- Full assessment and diagnostic processes are necessary to properly assess the subtle neurological impairments, learning difficulties, social and emotional challenges faced by children affected by FASDs
- Early diagnosis is a crucial step in preventing secondary disabilities