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SUBSPECIALIST CONSULT

Teens With an Autism Spectrum Disorder

The general pediatrician's role in managing an adolescent with an autism spectrum disorder depends largely on his or her comfort with doing counseling, testing, and medication management.

Most adolescents with an autism spectrum disorder already have a pretty thick chart from a history of pediatrician and pediatric subspecialist consultations, but the etiology question may remain. If a child's intelligence is within the normal range, a lot of elaborate medical testing generally is not necessary. If the child has cognitive dysfunction, such as an IQ below 70, there is a greater probability of finding an underlying cause for the disorder.

Consider separate counseling and procedural visits. Like many pediatric patients, one with an autism spectrum disorder can be anxious about vaccinations, needles, or any other unpleasant procedure. So if they know a particular visit is limited to a discussion of concerns, they

are more likely to relax and be more communicative.

Counseling will depend on the cognitive and language abilities of the patient. Discussions will have to be tailored to the level of understanding of the teen with autism spectrum disorder.

Counseling can include addressing sexuality issues. Discuss physical and emotional changes associated with adolescence and the effects they can have on the patient and the family. Teenagers in general are often confused about these changes, and those with autism spectrum disorder are no exception.

Discussions of the sort of sexual interest the patient has or does not have will depend on the patient's expressive capacity. Ask open-ended questions about any situations that may have arisen or about any concerns the patient may have about the future.

Also, educate the teen about the prevention of unwanted pregnancy and sex-

ually transmitted infections.

Medication management is important in this population. Many adolescents on the autism spectrum already take psychopharmacologic agents. There is a wide range of comfort levels among pediatricians regarding prescription of psychopharmacologic agents and management of behavioral challenges. Refer the patient to a specialist if you are not at ease in these situations.

Similarly, some pediatricians will be more comfortable than others in ordering and evaluating genetic testing.

Technology has advanced from general karyotype testing a decade ago to more accurate molecular fragile X assays and chromosome microarray analyses that are available today.

If you feel up to date based on your training and experience, go ahead and order initial testing or updated testing as indicated.

General pediatricians are well

equipped to manage any underlying medical issues. For example, if a patient has spells that might suggest seizures, an EEG might be in order, especially in this higher-risk population.

Start a transition plan once the adolescent is in high school. Pediatricians are integral in creating this plan, along with family physicians, internists, and/or other adult care providers.

Also work with school personnel to ensure an optimal outcome. Specific goals can include preparing the patient for postsecondary education or having the patient get necessary vocational skills as he or she becomes more independent and joins the workforce.

Work with parents to clarify goals for future living arrangements. Also suggest that parents establish a special needs trust to protect assets designated for the adolescent while still maintaining eligibility for government benefit programs. ■

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Breast Masses in Adolescents Seldom Found to Be Malignant

BY SUSAN LONDON

SEATTLE — Adolescent girls can develop a variety of breast masses, but fewer than 1% of the tumors are malignant, according to Dr. Paula K. Braverman.

"The most important thing about breast masses in adolescents is that they are very rarely cancer," said Dr. Braverman, a pediatrician specializing in adolescent health at Cincinnati Children's Hospital Medical Center. "But cancer is the first thing that the patient and the family are worried about. So you can reassure them: 'That is not what I'm worried about. Let's talk about the other things that could be going on.'"

She noted that in a review of 15 retrospective studies involving 1,791 girls and women, younger than age 22 years, who had a biopsy of a breast mass, the most common diagnosis was fibroadenoma, found in 68% (Neinstein L.S., ed. "Adolescent Health Care: A Practical Guide," 4th ed. Philadelphia: Lippincott Williams & Wilkins, 2002). Cancer was the cause in only 0.9% of cases.

Knowledge of normal breast development is key to evaluating masses in adolescents, according to Dr. Braverman. "Breast development starts with

the breast bud," she said. "You need to be able to recognize the breast bud because it is not an abnormality."

Fibroadenomas are smooth, rubbery, mobile, firm nodules that are usually very well demarcated and have an average



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DR. BRAVERMAN

size of 2-3 cm, she noted. "They can last for an average of about 5 months, and can be recurrent and multiple."

Fibroadenomas are usually benign. Because of this, she advised against repeatedly performing biopsies of similar masses in an adolescent after a first biopsy has proven a mass to be a fibroadenoma. Multiple surgical procedures can cause disfigurement, and it would be better to hold off until breast development is complete unless there are characteristics of the mass that suggest it is not benign.

Intraductal papilloma, in addition to causing a mass, can also cause a bloody nipple dis-

charge. These masses usually occur in the subareolar position. "Although intraductal papilloma is benign, it should be excised," Dr. Braverman said at a meeting of the American Academy of Pediatrics.

Juvenile giant fibroadenomas are very rapidly growing masses. "These masses are also a benign condition, but [they] can grow to be very large—more than 5 cm in diameter," she said. These masses can be disfiguring, replacing or compressing the normal breast tissue, which is why they need to be removed."

Cystosarcoma phyllodes, also called phyllodes tumor, can likewise cause a rapidly growing large mass in adolescents that also warrants removal. "Phyllodes tumors are usually benign, but there is a small possibility of malignant transformation," Dr. Braverman noted.

Fibrocystic breast disease creates thickenings and lumps that are generally most pronounced in the week before menstrual periods and regress in between. "Fibrocystic disease is usually totally benign," she said. In adolescents, the symptoms can be addressed with a supportive bra, mild analgesics such as non-

steroidal anti-inflammatory drugs, and oral contraceptives.

Infectious masses include both breast cellulitis and breast abscesses, said Dr. Braverman. Treatment typically entails application of warm compresses and antibiotic therapy. "You want to try to avoid incision and drainage, if possible, because it can cause damage to the breast tissue," she advised.

Cancer in the adolescent breast is not only rare, but also unlikely to be a primary breast cancer, according to Dr. Braverman. "When we do see malignancies in adolescents, the majority of masses are metastatic lesions from nonbreast tissue. Unlike benign breast masses, those that are cancer usually manifest clinically as masses that are hard and fixed to deep tissue.

Dr. Braverman recommended following the mass through several menstrual cycles. "If the breast mass or breast changes totally resolve between menses, you know that you do not have a problem that you need to worry about.

"If you have a persistent mass or a mass that is growing, the imaging that you want to do in a teenager is ultrasound," she said. Mammograms are not useful because the breast tissue is too dense. If the diagnosis re-

mains uncertain after ultrasound, the patient should be referred to a breast surgeon to be evaluated for a possible excisional biopsy.

Some adolescents may have a family history of breast cancer or known BRCA1 or 2 mutations. Testing for these mutations, however, should be deferred until the adolescent is an adult (usually 18 at a minimum). "It is better for the teen to decide when they are an adult, when they can make that decision for themselves about whether they want to have this genetic information."

In addition, she said, even if one of these mutations is present, initiation of mammographic screening is not recommended until the age of 25-35 years.

Among women with a family history of breast cancer, studies suggest that low-dose birth control pills do not appear to increase the risk of breast cancer beyond the underlying predisposition of these women. So consider giving low-dose birth control pills to adolescents "even when there is a family history of breast cancer or BRCA mutations," she said.

Dr. Braverman reported that she had no financial conflicts of interest relevant to her presentation. ■