An Urgent Care Approach to Excessively Crying Infants

Urgent message: Infants who cry excessively pose a challenge to physicians and parents. A systematic approach to the history and physical exam can guide the diagnostic approaches to determine if a benign—or serious—condition is responsible.

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Crying is a primitive form of communication that infants rely on to communicate their distress. Because infants cannot verbalize their discomfort, they must rely on their cry to communicate with caregivers.

Estimates indicate that infants cry a total of 1 to 2 hours per day. Newborns cry the least, but crying steadily increases during the first few weeks to a peak of approximately 3 hours per day at about 6 to 8 weeks of life, after which it declines. It is often the excessive crying, when the total hours are consolidated or when the infant is inconsolable, that is the most stressful for parents.[1]

Parents may complain of excessive crying or excessive fussiness and may describe their infant as "colicky" or irritable. Most parents seek care when they are concerned that there is a serious medical problem responsible for the crying, whereas others seek care when they have become exhausted.

The list of potential etiologies for excessive crying can be exhaustive, but studies suggest that from 5% to 60% of infants evaluated in an emergency department (ED) for excessive crying have a serious medical condition.[2-3] A more recent, prospective study of 254 infants presenting to an ED for excessive crying found that 5% of those infants had a serious medical condition.[2]

The differential diagnosis of prolonged crying or fussiness in an infant is quite long (Table 1). It ranges from benign colic to serious conditions, such as meningitis, congenital heart disease (CHD), and abusive head trauma. As the physician, you must be able to differentiate between benign and serious causes of excessive crying.

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A careful history and full physical exam is essential in determining the cause of excessive crying. Studies have demonstrated that 66% of infants are found to have a cause for their crying when positive findings on history and physical exam are combined.[2-3] In 2.5% of the

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Table 1. Differential Diagnosis of Excessive Crying in Infants

Benign	Serious/Life-Threatening
Anal Fissure	Abusive head trauma/child abuse
Colic	Congestive heart failure
Corneal abrasion	Congenital heart disease
Feeding difficulties	Supraventricular tachycardia
Gas	Drugs or drug withdrawal
Hair tourniquet	Incarcerated hernia
Hernia (unincarcerated)	Infection
Milk protein allergy	Sepsis
Nasal congestion	Meningitis
Otitis media	Respiratory distress
Oral thrush (severe)	Urinary tract infection
Gastroesophageal reflux	Injury
	Intussusception
	Metabolic disturbances
	Testicular/ovarian torsion

infants, the history or physical exam leads directly to the diagnostic evaluation necessary to determine the cause. It is also notable that 27% of the infants seen with a normal history, physical exam, and diagnostic evaluation (if performed) had "crying" as their final diagnosis.[2]

History and Physical Exam

When trying to understand an infant's excessive crying, it is important to understand its onset and duration and the factors that relieve or exacerbate it. Paying careful attention to any relationship to feedings is incredibly important when trying to determine the etiology. Changes in feeding behaviors may indicate the presence of neurologic, cardiovascular, respiratory, gastrointestinal (GI) or metabolic conditions.

Past medical and social history are just as relevant as the history of present illness. The past medical history of an infant must always include maternal history, including details of labor and delivery, any maternal infections, perinatal or neonatal complications, current maternal medication history (and illicit drug history) as well as status of breastfeeding. Recent changes in care arrangement (has mother recently returned to work) can lead to behavioral changes and prolonged crying in an infant. Assessing the parents' support system is also important. Sleep deprivation and other psychosocial stressors can lower parents' threshold to help soothe their child and may change their perception of how excessive the crying is.

Full physical examination of a child, including removing all clothing and diapers, is imperative. During your exam, always include careful observation of the infant with the parent, taking time to observe whether and how the infant is consoled. Parental stress and anxiety related to infant crying may impede the ability to console an infant.

History of Crying or Fussiness

To acquire a better understanding of an infant's crying, it is important to approach the history systematically. Start by asking the parent what is most concerning. A parent's instinct should not be dismissed.

Onset: Did the crying start today or several days ago? Was there a precipitating event? How long ago did the crying become excessive? What time of day does it typically occur?

Provocation and palliation: What seems to make the pain worse (feeding, lying down, sitting up, or holding in a certain position)? What seems to make it better (feeding, burping, passing gas or stool, swaddling or rocking)? Is there vomiting or spitting up associated with the crying and, if so, does that relieve or exacerbate it?

Quality: Does the parent consider the infant to be "in pain" or "somewhat fussy?" Understanding whether the crying is episodic/paroxysmal is important.

Region and radiation: While infants may not be able to localize their pain, pay careful attention to positions that may exacerbate or relieve the pain.

Severity: To a parent, fussiness may always seem excessive, but try to determine how it differs from other episodes of crying.

Timing: Is the crying associated with feeding or positioning? Was it sudden upon awakening? Have there been any changes in the infant's diet or recent vaccinations?

Review of systems should also include presence of fever, weight loss or gain, interest in feeding, volume of feeding, presence of vomiting, excessive sleepiness or having to wake to feed.

Physical Exam

A complete head-to-toe physical exam of the infant—with clothing and diaper completely removed—is essential in determining a source of crying.

Vital signs: Is the infant febrile, tachycardic or tachypneic? These can be markers of infection/sepsis, cardiovascular or respiratory disease or metabolic derangements. Normal ranges for vital signs vary by infant age, but it is important to understand what is considered out of range.

General: Is the infant lethargic or asleep, but arousable? Is the infant crying or generally fussy? Has the crying subsided? If crying, is he/she easily consoled? Infants who are lethargic or remain persistently irritable during your exam are more likely to have a serious cause for their crying.

Skin: A careful skin exam for any swelling or evidence of cellulitis/abscess, especially in less-evident places such as skin folds in the neck and perirectal area, is important in the era of community-acquired multi-drug resistant *Staphylococcus aureus* infections. Skin mottling and acrocyanosis can be normal in newborns, but in the presence of other physical exam findings, such as fever or lethargy, they may be markers of shock. Petechiae and purpura are late findings in sepsis.

Head, ears, eyes, nose, and throat: Assess the fontanel for fullness/bulging (concern for meningitis) and the skull for swelling or bogginess (concern for skull fracture). A bulging fontanel is a late sign of meningitis and will be accompanied by other concerns for sepsis and infection (poor perfusion, lethargy). Be sure to examine the mouth for thrush or oral lesions (using a tongue depressor) and always check the ears. Eyes may be injected or tearing if there is a corneal abrasion or foreign body, but they also may appear normal, so consider fluorescein for any irritable infant without other physical exam findings.

Cardiovascular and respiratory: Assess perfusion, peripheral pulses, heart rate, and presence of a heart murmur as indicators of congenital heart disease. Respiratory distress, marked by tachypnea, wheezing or grunting, may indicate respiratory or cardiovascular diseases. In addition, poor feeding, tachypnea/sweating during feedings or failure to thrive may indicate congenital or acquired heart disease. Congenital heart disease may also manifest as

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Table 2. Excessive crying by system

HEENT
Skull fracture[a]
Corneal abrasion/foreign body[a]
Nasal congestion*
Oral thrush[a]
Otitis Media[a]

Cardiovascular/Respiratory
Congestive Heart Failure[b]
Congenital Heart Disease[b]
SVT[a]
Respiratory distress/infection[a]

Colic

Gastrointestinal
Anal fissure[a]
Feeding difficulties[b]
Gas[b]
Intussusception
Milk protein allergy[b]
Reflux[b]

Genitourinary
Diaper dermatitis[a]
Hernia[a]
Testicular[a]/ovarian torsion
Urinary tract infection

Musculoskeletal
Abscess, burn, cellulitis[a]
Child abuse[b]
Hair tourniquet[a]
Injury/Fracture (accidental)[a]

Neurologic
Meningitis
Abusive head trauma

Toxic/Metabolic
Drugs or drug withdrawal
Metabolic acidosis
Hypernatremia, hypocalcemia, hypoglycemia
Recent vaccination (DTaP)

DTap = diphtheria, tetanus, and pertussis; HEENT = head, ears, eyes, nose, and throat; SVT = supraventricular tachycardia
[a]Physical exam findings are often present
[b]History will often offer clue

cardiovascular collapse, congestive heart failure (CHF) or failure to thrive.

GastrointestinaI: Palpate for abdominal masses, abdominal distension, abdominal tenderness, and tenseness. In the setting of irritability, these are concerning for intra-abdominal processes. Perform a guaiac stool test for presence of blood. Parents often complain that an infant's abdomen is hard when crying (because of contraction of abdominal muscles), but it should be soft when an infant is relaxed.

Genitourinary: Remove the diaper to check for hernias and testicular torsion. Lay the infant in the supine position and flex the hips to better visualize anal fissures or perirectal abscesses.

Musculoskeletal: Palpate all long bones and clavicles. Are there areas of swelling, bruising or erythema? Does the crying increase when you move an extremity? These would raise concerns for musculoskeletal trauma. Look at all fingers and toes to be sure there are no tourniquets.

Neurologic: Is the child consolable at all? Paradoxical irritability (crying is made worse when holding to try to console) can be seen with meningitis. Is there hyper or hypotonicity?

The history (combined with a normal physical exam) will help in diagnosis of colic, feeding difficulties, gastroesophageal reflux, cow's milk protein allergy and drug exposure and withdrawal.

Your physical exam will establish the diagnosis in cases of thrush, otitis media, skin infections, hair tourniquet, hernia, testicular torsion, anal fissure, musculoskeletal injury or other trauma.

A combination of history and physical exam is important in determining whether diagnostic procedures should be done to rule out meningitis, urinary tract infection (UTI), intussusception, CHD/CHF, abusive head trauma (AHT) and metabolic derangements.

Diagnostic and Therapeutic Measures for Specific Conditions

(listed alphabetically)

Abusive Head Trauma

AHT is cause by repeated shaking of an infant. The shaking initially causes cerebral injury secondary to shearing of axons as well as bridging blood vessels leading to cerebral edema and subdural hemorrhage. This manifests early as crying and inconsolability. As the cerebral edema continues, the infant may have apnea, seizure, lethargy and coma.[4]

In most cases of AHT no history of abuse is provided during the initial visit, therefore, the clinician must have a high index of suspicion. Any concern for AHT should prompt transfer to a pediatric facility for further evaluation.

Cardiac conditions

CHD, if not detected on fetal ultrasound, may not manifest until the first week of life following changes in neonatal physiology. Infants with critical cardiac defects will present with signs of CHF and poor perfusion. Infants with milder defects may present with irritability, poor feeding or respiratory distress such as tachypnea or grunting during feeding. A murmur may or may not be present on initial exam.

Obtaining a chest x-ray, four extremity blood pressures, and electrocardiogram may help to determine the type of defect. If you are concerned about a cardiac abnormality, transfer to the nearest pediatric facility.

Supraventricular tachycardia (SVT) may present at

any age. In infants, heart rate is >220 bpm and SVT may manifest as an asymptomatic tachycardia, irritability, respiratory distress, or poor feeding. If an episode of SVT is prolonged it may result in complete cardiovascular collapse. Treatment is aimed at stopping the arrhythmia and immediate consultation with a pediatric cardiologist is required.

Colic

Crying in excess of 3 consecutive hours per day for more than 3 days out of the week in an otherwise healthy infant is the commonly accepted definition of colic. Generally, the prolonged crying is clustered later in the day. It usually begins by age 6 weeks and lasts up to 3 to 4 months.

There are many theories as to what causes colic, ranging from gut immaturity to release from stimulation throughout the day. Infants are described as being inconsolable for prolonged periods. Colic is a clinical diagnosis based on the above history coupled with a normal physical exam.

Care for colic is supportive (of the infant and the parent). Soothing techniques such as swaddling, rocking, swinging or car rides are all variably helpful, but will not completely prevent the crying. Excessive crying due to colic usually resolves by 4 months of life.

Corneal abrasion

Corneal abrasion is usually accidental as infants begin to gain control over their extremities. It may be the result of a foreign body such as an eyelash. The eye may be injected or tearing and there may be some degree of photophobia. Although there may be no history of injury, the history of crying is often acute in onset and the infant is inconsolable despite soothing techniques.

Performing a fluorescein exam with instillation of a topical anesthetic will reveal the abrasion and relieve the pain. This procedure will be both diagnostic and therapeutic. Evert the eyelids to determine presence of a foreign body.

Most corneal abrasions will resolve within 24 hours and do not require specific treatment or follow up. Larger abrasions should be referred for follow up the next day. Consider antibiotic ophthalmic ointment for relief and prevention of superinfection for significant abrasions.

Feeding difficulties, reflux and cow's milk protein allergy

Feeding difficulties can range from problems with nursing or bottle-feeding to gastroesophageal reflux to feeding intolerance and cow's milk protein allergy.

One common cause of feeding difficulties is excessive gas. This is caused by swallowing excessive air while feeding. However, if an infant is unable to burp and release the swallowed air from the stomach it will pass further into the digestive tract. The increase in air can cause discomfort until it is passed. Parents may have already tried simethicone for gas relief, which is not consistently effective but is safe for infants.

All infants have some degree of gastroesophageal reflux. Reflux of stomach contents is physiologic due to immaturity of the lower esophageal sphincter. The practice of feeding infants in a reclined position is another contributing factor. Most reflux is asymptomatic except for some occasional "spit up." Clinically significant gastroesophageal reflux esophagitis or gastritis usually presents with crying after or between feedings. More significant reflux can present with painful episodes of crying and arching of the back. Severe reflux may lead to refusal to eat because of pain and eventually failure to thrive. Occasionally infants will seem to feed more often because the formula may coat the esophagitis and provide relief.

Supportive care is recommended for most infants. This is most often accomplished by keeping an infant in an inclined to upright position for about 30 minutes following feeding. Pharmacologic treatment is recommended for infants with significant reflux that causes failure to gain weight or those with significant irritability throughout the day. Both H_2 blockers and proton pump inhibitors are used in infants with reflux.

If you are evaluating an infant you suspect of having reflux, you can offer 2 to 4 mL of aluminum hydroxide and magnesium hydroxide liquid antacid as a therapeutic intervention. If the crying and irritability resolve within several minutes, an infant likely has esophagitis. Liquid antacid can be given at home, at a dose of 1 to 2 mL up to four times daily, as needed. I often recommend adding an acid reducer if a liquid antacid is needed on an ongoing basis.

Food protein-induced proctocolitis, formerly referred to as cow's milk protein "allergy," is caused by a non-IgE-mediated hypersensitivity to the cow's milk (or soy) protein in commercial formula. Infants who are exclusively breastfed may also develop this disorder from dairy in the mother's diet. This typically presents between 2 and 8 weeks of life. In its mildest form, there is a distal colitis, which presents with small amounts of gross or microscopic blood in the stool, but generally without vomiting or diarrhea. Symptoms of fussiness may precede the blood in the stool. More severe forms

of protein-induced sensitivity may cause both vomiting and bloody stool. Treatment is initiation of hypoallergenic formula with hydrolyzed protein and elimination of dairy from the nursing mother's diet. Improvement is expected within 3 days, but may take up to 1 week. Most infants outgrow this intolerance by 1 year. Follow up with gastroenterology is recommended if there is no improvement after elimination of the offending protein.

Hair tourniquet

Hair or other thread tourniquets can be found on the phalanges as well as the penis. They occur because of repeated exposure to the hair in a confined space such as the diaper, mittens or socks. Swelling and edema is seen distal to the tourniquet and will eventually cause vasoconstriction. In some cases, the tourniquet may be completely embedded in the skin.

Removing the tourniquet can be a challenge because of significant swelling or the nature of the fiber itself. If you can find the leading end, you may be able to unwrap it or if you are able to insert a blunt probe fully under the hair, you can simply cut the tourniquet. However, if the hair is embedded and you are unable to remove the tourniquet, the child should be referred to the nearest pediatric center to have the constricting band incised.

Hernia

Inguinal hernias can occur at any age and may present in both boys and girls as a mass or bulge in the groin. In boys, a hernia may extend into the scrotum as a scrotal mass. Patients with incarcerated hernias that cannot be reduced should be referred immediately to a pediatric surgeon. Reducible hernias should be followed up as an outpatient for eventual surgical repair.

Intussusception

Intussusception is most common in infants aged 3 to 24 months and often presents with paroxysm of pain causing them to cry out and pull up their legs. Pain is episodic, occurring every 15 to 30 minutes, and increases in frequency as the obstruction progresses.

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These episodes may be followed by periods of lethargy. A sausage-shaped mass in the abdomen may be palpable. Bloody or "currant jelly stool" is a late finding.

The episodes of pain are caused by constriction of the intussusceptum (the ileum along with its mesentery) into the intussuscipiens (most often the cecum). This can lead to eventual intestinal edema, ischemia, and peritonitis.

Intussusception is a surgical emergency. Attempts at reduction with barium or air contrast enema should be done at a pediatric center as there is a risk of perforation or non-reduction that would require emergency surgery.

Meningitis

Meningitis occurs in <1% of infants younger than age 2 months. However, meningitis is a serious infection that may have long-lasting complications even if treated promptly. It is often accompanied by fever, poor feeding, and irritability. A bulging fontanel is only present in approximately 25% of infants with meningitis.

A lumbar puncture with cell count and culture will help determine the presence of meningitis. Once stabilized, promptly transfer infants with concern for meningitis. If you are unable to obtain a lumbar puncture, do not hesitate to give intravenous antibiotics if you are clinically concerned that an infant has meningitis.

Metabolic

Metabolic disturbances caused by inborn errors of metabolism may not manifest for the first few weeks of life, given the prior interaction with maternal circulating hormone and metabolism in utero. Most metabolic derangements will also be associated with poor feeding, poor weight gain, lethargy and vomiting and will rarely present as excessive crying alone.

Hypernatremia may be the result of inappropriate mixing of infant formula (adding too little water to concentrated or powder formula) and can present at any age in infancy.

Respiratory conditions

Infants with respiratory distress may present with grunting that a parent may interpret as irritability or fussiness. Respiratory distress in infants may be primary, caused by infections (bronchiolitis or pneumonia) or secondary, as a result of CHF from a congenital heart defect (see *Cardiac Conditions* above). Tachypnea, without other signs of respiratory distress, may be a compensatory response to metabolic acidosis from an inborn error of metabolism.

Treatment should be aimed at the minimizing the distress and determining the cause.

Trauma or injury

Trauma may be accidental, caused by a fall from an infant seat or changing table, or may be non-accidental and from child abuse. Infants with a fracture will present with crying especially when moving the injured body part. Palpation of the extremities is important, because swelling may not be obvious in infants who have significant subcutaneous tissue.

Clavicle injuries may occur after a fall from a raised surface (rolling off a changing table or couch). Such injuries will elicit increased pain when lifting the child from under the axillae because this causes the clavicle to elevate. Swelling initially may be minimal, but if a child is examined 1 to 2 days after the injury, a callous will be present. X-rays will help determine the presence of facture.

If an infant's injury does not seem consistent with the history provided by the parent or if it is not consistent with the child's developmental stage, it should raise the suspicion for abuse. Bruising in infants who are not cruising or bruising to the pinna, mouth, or abdomen in any child as well as injuries to the genitalia should also raise suspicion for abuse.[5] Do not hesitate to contact your local child protection team in these cases.

Testicular/ovarian torsion

Testicular torsion will present as a scrotal mass with tenderness and often with surrounding erythema and induration. Infants are often quite irritable and may have a history of vomiting.

Ovarian torsion in infants is rare. Although physical exam findings are non-specific, an infant will often present with signs of acute abdomen including abdominal tenderness, vomiting and irritability.

Both of these conditions are a surgical emergency. Infants should be transferred to the nearest pediatric center for further evaluation and management.

Toxins/drug withdrawal

Toxins or other drugs may be present in over-the-counter medications imported from foreign countries or in some cultural home remedies.

Even in the absence of illicit drug use, prescription narcotic drug withdrawal can be a cause of fussiness. Narcotic pain relievers are prescribed for a variety of reasons including pain associated with cesarean section or maternal mastitis. While they are safe to use during breastfeed-

ing, they are found in breastmilk and can be a source of withdrawal if abruptly discontinued by the mother. Symptoms of narcotic withdrawal in an infant are excessive crying, irritability, poor feeding and diarrhea. Care is often supportive and aimed at decreasing exogenous stimulation and giving small, frequent feeds.

The diphtheria, tetanus, and pertussis vaccine (DTaP) can cause excessive crying, usually beginning within 4 to 6 hours after administration and lasting for 6 to 24 hours. In the case of recent vaccination, be sure to check the extremities for signs of swelling at the injection site, which may be a source of pain and inflammation (but rarely a source of infection).

Urinary tract infection

Signs and symptoms of urinary tract infection (UTI) in infants include fever, vomiting, diarrhea and irritability. One study suggests that infants who present for emergency care with chief complaint of crying, even in the absence of fever, may have a UTI. Overall risk of UTI changes with age and gender. Although the authors do not advocate screening for UTI in the crying infant, UTI should be considered in the differential for an irritable infant.[2]

Age-specific considerations

Infants <28 days

Even to the most experienced pediatrician, infants younger than age 28 days are always a diagnostic challenge because they provide few clues to the etiology of their crying. If you are evaluating an infant who remains inconsolable, in the absence of abnormal physical exam findings, you should always consider serious bacterial infection as a cause, even without fever. Signs and symptoms of neonatal sepsis may be non-specific and may include temperature instability (hypothermia or fever), apnea, irritability or lethargy.

Although the overall risk of serious infection is low (<1%), the morbidity and mortality remain high (10%), therefore you should have a very low threshold to transfer the persistently irritable neonate to a pediatric center for further evaluation and management.

Psychosocial Support

Excessive crying in an infant often triggers feelings of inadequacy and frustration on the part of the parent, especially when coupled with sleep deprivation. Acknowledging to the parent that caring for a crying infant is challenging and giving the parent permission to take a break from the seemingly incessant crying is

in more ways than one.

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an important piece of anticipatory guidance. Parents should be encouraged to seek support from other family members and friends in caring for their crying infant.

It is extremely important to counsel parents about the dangers of shaken baby syndrome (abusive head trauma).

Conclusion

A crying infant poses a challenge to both parents and clinicians. Taking the time to review a thorough history and physical exam will often lead to the diagnosis. In the urgent care setting, it is important to rule out the most acute and life-threatening illness or injuries.

Infants who are not well appearing, who remain inconsolable during your evaluation or who have other worrisome signs such as lethargy, fever, poor feeding, difficulty breathing, persistent vomiting or failure to thrive should be referred to the emergency room for further evaluation.

Otherwise well-appearing infants with excessive crying often will be diagnosed with colic or feeding difficulties/formula intolerance. In cases of colic, providing information about the natural history will be helpful in letting parents know that there is an end in sight. In cases of reflux or formula intolerance, close follow up with a pediatrician or family practitioner will ensure continued support and possible further diagnostic work up on an outpatient basis.

All infants evaluated for irritability or excessive crying should be referred back to their primary care provider for close follow up. ■

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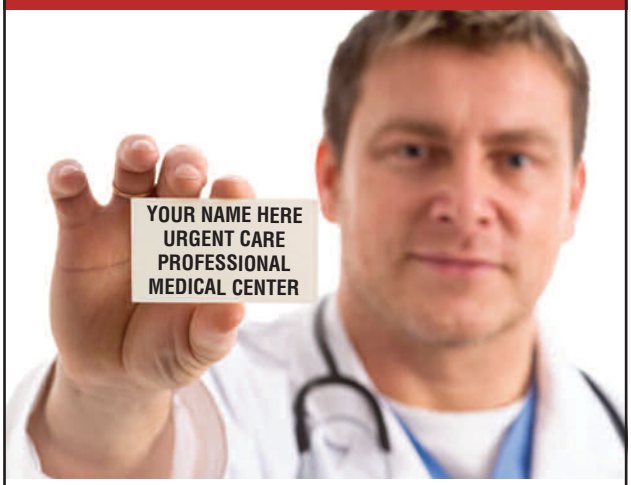

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