Commentary

Psychosocial Risk and Health Care Utilization in Pediatric Sickle Cell Disease

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Introduction

The article "Psychosocial risk and health care utilization in pediatric sickle cell disease" by Kerri E. Woodward et al. was read with utmost seriousness and deep curiosity [1]. It was enjoyable to go through the well-concisely written and straightforward prose and we appreciate the authors for their remarkable efforts.

We concur with the ultimate findings of the study that greater pain frequency and family financial need are indicative of greater psychosocial risk leading to more healthcare utilization. However, there are some additional considerations that we believe would have enhanced the quality and final outcome of the study.

The sample matching would have elicited numerous inquiries regarding the accuracy of results. Inclusion of children other than age 8-18 years and with any genotype of Sickle Cell Disease (SCD) may have impacted the outcome. For illustration, children who experienced disease related pain in past 30 days, age 8-21, having experienced at least one SCD pain episode in the past year (i.e. at least 20 minutes of SCD pain), with any phenotype of SCD, children of any race or ethnicity, caregivers if they were the child's parent, legal guardian or grandparent were included [2-6] Moreover, the authors could have employed broader exclusion criteria to mitigate any potential bias. For example, children with diagnosis of sickle cell trait only, using opioid drugs for pain, patients currently being hospitalized, history of noncompliance as indicated by the healthcare provider, or who were currently receiving a sleep intervention were excluded. Furthermore, the authors also missed few factors associated with increased parenting stress and healthcare utilization. According to a study, more missed school days of child, poorer physical health and decreased socialemotional functioning of caregiver are associated with increased parenting stress [5]. Sickle cell genotype also plays a role in healthcare utilization as children with high-risk genotypes had higher pain intensity and healthcare utilization versus children with low-risk genotypes [6]. The authors also had the opportunity to classify SCD pain. For instance, a study grouped patients with SCD related pain into chronic and episodic and concluded that the chronic pain group had significantly higher number of healthcare utilizations and contributed to poorer psychosocial outcomes [7]. Finally, the authors should have provided details on other tests and methods to assess the patient's or parent's state of health. To illustrate, Pediatric Inventory for Patients (PIP) instrument was used to assess parents stress whose child has a chronic illness, GAD-7 was used to screen for symptoms of anxiety, Functional Disability Inventory (FDI) instrument was used to assess children's perceived difficulty to perform daily activities in home and school, and pain-related beliefs and attributions in youth was assessed by Pediatric Survey of Pain Attitudes (Peds-SOPA) [5, 7].

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