Autism spectrum in children

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Introduction

Autism spectrum is firstly defined by the difficulty of the child to interact with the community and limiting , repeating way one normally behaves .

The psychiatric Leo Kanner was the one who firstly described the autism disorder in 1943 as a disorder in children who had issues related to others and sensitive to any changes in their environment as it rarely seen at this time the prevalence of Autism Spectrum Disorder (ASD) steadily increased . ASD may have a higher incidence of obesity than children without a disability, sleep problems, gastrointestinal disturbances are commonly seen.[1]

Symptoms and causes

Social deficits and delays in spoken language are the eminent feature in children younger than three years. Unusual play patterns may be noted ,such as focus on a specific part of a toy. Children with ASD may demonstrate stereotypic movements, such as hand flapping, toe walking, or finger flicking near their eyes .[2,3]

Marked deficits in verbal and nonverbal social communication skills; social impairments are obvious even with the endorsements in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others.

Non-specific non-optimal factors during pregnancy, including maternal metabolic conditions, weight gain, and hypertension, as well as more precise factors (such as maternal admission to hospital due to bacterial or viral infections, or familial history of auto-immune disease) have also been linked with a mildly increased risk of ASD and developmental delay combined. The genetical or environmental facts is the only two ways involved in the (ASD) .
A meta-analysis published in 2016 reported that 74–93% of ASD risk is Heritable .
Sibling studies indicate that ASD occurs in 7–20% of subsequent children after an older child is diagnosed with ASD,76,77 and this prevalence is increased in children with two older siblings with ASD. Risk is 3–4-times higher in boys than girls. [4]

Materials and methods

The appraise aim to definitively diagnose ASD, exclude conditions that simulate ASD, identify comorbid conditions, and specify the child's level of functioning. In the absence of a team, an individual clinician with expertise in evaluating ASD (e.g., child psychologist, developmental pediatrician). [5] The evaluation should include a complete history and direct assessment of social communication skills and restricted, repetitive behaviors using a semi-structured tool (e.g., the Autism Diagnostic Observation Schedule,2nd ed.) with standardized testing of language and cognitive skills. The diagnosis must be confirmed using the DSM-5 criteria for ASD.

Behavioral treatment and medical Management

It seeks to teach new skills
by reinforcing desirable behaviors, encouraging generalization of these skills, and reducing unwanted behaviors.
In a stepstoned study published in 1987 based on the principles of applied behavior analysis, one-half of the patients assigned to the recuperation were able to be placed in a neurotypical classroom and complete first grade.

Medical management may also target comorbid diagnoses, such as anxiety disorders, attention-deficit/ hyperactivity disorder (ADHD),and sleep disorders. Underlying conditions such as headaches, sinusitis, and gastrointestinal disorders.
These conditions should be ruled out before initiating targeted therapy.[6]

Aripiprazole (Abilify) and risperidone (Risperdal) are the only medications approved by the U.S. Food and Drug Administration for the treatment of ASD.

References

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