When I searched “VEOID” on-line after a recent presentation by Dr Jonathan Derrick, paediatric SHO, Google helpfully asked “Did you mean: video”. So, Jon is delighted to share information with you on an emerging type of inflammatory bowel disease in the very young that not even Google knows about...

LESSONS FROM THE FRONT LINE:

VEOID = Very Early Onset Inflammatory Bowel Disease

A 2½ year old Asian male presented with a 3-month history of bloody diarrhoea and peri-anal erythema. Mother was mainly concerned about the nappy rash and the long history of blood in the diarrhoea was only elicited on a ward round post admission. He had been treated for viral gastroenteritis and then zinc deficiency. He had lost 3 kg in weight at presentation and looked anaemic.

The child was pale, flushed and looked unwell with a tender abdomen. Hb was 70, CRP 200, ESR 160, WCC 22. Stool samples were negative for McBS & virology, faecal calprotectin was 4,300. An AXR showed colonic thickening. The child received IV Ciprofloxacin and a blood transfusion. A referral was made to tertiary gastroenterology and following a colonoscopy the child was diagnosed with Very Early Onset Inflammatory Bowel Disease (VEOID) affecting his large bowel.

Take Home Message: VEOID is increasing in incidence. NICE in 2009 (https://pathways.nice.org.uk/pathways/diarrhoea-and-vomiting-in-children) asked us to investigate diarrhoea if there is blood in it. Ask parents the direct question, “Is there any blood or mucus in the diarrhoea?”. Bloody diarrhoea and weight loss = significant pathology.

After MSK involvement, dermatological lesions are the second most common extraintestinal disorders of IBD with 1/3 of patients having some sort of rash (Pellicer Z et al. Management of cutaneous disorders related to inflammatory bowel disease. Ann Gastroenterol 2012; 25(1): 21–26). This child’s nappy rash was secondary to his IBD.

FAQs on VEOID answered at Snapper S. Very–Early-Onset Inflammatory Bowel Disease. Gastroenterol Hepatol 2015 Aug; 11(8): 554–556. Defined as symptoms appearing < 6 yrs of age. There is an infantile type which develops in children under 2. Incidence is increasing, possibly involving the interaction between genetic influences and as yet unknown environmental factors.

Other causes of bloody diarrhoea in children


INFANTS UNDER 1 YEAR OF AGE

Common causes:

Intestinal infection
Infant colitis
Non-specific colitis
Breast milk colitis
Cow’s milk colitis

Less Common or Rare:

Intestinal ischaemia
Intussusception
Malrotation and volvulus
Neonatal enterocolitis
Hirschsprung’s disease
Inflammatory bowel disease
Crohn's colitis
Ulcerative colitis
Systemic vasculitis
Fainting illness

CHILDREN OVER 1 YEAR

Common causes:

Intestinal infection
Inflammatory bowel disease
Crohn’s colitis
Ulcerative colitis
Juvenile polyposis

Less Common or Rare:

Intestinal ischaemia
Intussusception
Malrotation and volvulus
Mucocutaneous syphilis
Henoch-Schönlein purpura or other forms of systemic vasculitis
Fainting illness

What actually is acanthosis nigricans?

The pathogenesis is poorly understood. Possibly caused by increased growth factor levels on keratinocytes with insulin-mediated activation of ILGF growth receptors playing a part. Characterised by darkening and thickening of skin folds in axilla, groin and back of neck. Not a disease itself but a sign of an underlying condition. In children, most often obesity-related hyperinsulinaemia. Consider malignancy in adults.

What to do in primary care with an obese child with acanthosis nigricans:

- Screen for type II diabetes and metabolic syndrome (co-existing coronary artery disease, hypertension and diabetes) – fasting insulin, glucose, HbA1c and lipid profile
- Consider polycystic ovarian syndrome in a young person with acanthosis nigricans, hirsutism, acne and irregular periods
- Correct hyperinsulinaemia through diet and medication (eg. metformin)
- Lose weight. Tertiary obesity services will accept children whose BMI is > 99th centile and they have a co-morbidity of which acanthosis nigricans is one example. Start families off with Paediatric Pearls’ healthy lifestyle handout and a referral to your local weight management service (eg. https://www.henry.org.uk/).

There is a comprehensive article available: Phiske MM. An approach to acanthosis nigricans. Indian Dermatol Online J. 2014 Jul-Sep; 5(3): 239–249.

For parents: https://kidshealth.org/en/parents/acanthosis.html

CROUP clinical assessment tool from Birmingham Women and Children’s. I mentioned this website last month as an excellent resource for GPs. It also houses very clear assessment tools for ED practitioners. Here is their traffic light system for identifying the severity of croup:

Table 1: Traffic light system for identifying severity of illness

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Respiratory rate</td>
<td>Severe</td>
<td>Moderate</td>
<td>Normal</td>
</tr>
<tr>
<td>Haemoptysis</td>
<td>Severe</td>
<td>Moderate</td>
<td>None</td>
</tr>
<tr>
<td>Temperature</td>
<td>High</td>
<td>Moderate</td>
<td>Normal</td>
</tr>
<tr>
<td>Heart rate</td>
<td>Very fast</td>
<td>Fast</td>
<td>Slow</td>
</tr>
<tr>
<td>Cyanosis</td>
<td>Severe</td>
<td>Moderate</td>
<td>None</td>
</tr>
</tbody>
</table>

The 10 page guide to croup is available here. It includes this excellent patient information resource which uses the same safety netting format as the West Sussex resources available here.

What written safety net information are you giving your patients?

Croup Advice Guide: