# Paediatric Pearls

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**Previous editions are all available at www.paediatricpearls.co.uk**

## Measles

We have seen measles cases in this area in the last couple of weeks and are expecting more. It is highly infectious (90% of non-immune contacts will get it if in contact with an infectious person for 15 mins).

**Symptoms reminder:**

**Fever and generalised maculopapular rash**
**Cough**
**Coryza**
**Conjunctivitis**
**Koplik spots (white spots on buccal mucosa but they may have gone by the time the rash appears)**

http://www.bbc.co.uk/news/health-22173393 has a good summary of symptoms and the MMR controversy if patients want a succinct version. Patient info on measles at: http://www.patient.co.uk/health/Measles.htm

The child is infectious for 4 days before the onset of the rash and 4 days after its onset

### MMR:

- Can be given up to 3 days post exposure to a case
- Is safe to give even if the contact is already immune
- Can be given from 6/12 of age with no upper age limit
- Will lead to seroconversion in 95% of cases after just one dose, 99-100% seroconversion in a population given 2 doses
- If immunising children under 1 year as contacts or during the expected outbreak, they still need to follow the normal schedule of 13 months and pre-school booster as well. Any child given their second dose before the age of 18/12 will still need a pre-school booster as well.
- Patient information sheet on MMR at http://www.patient.co.uk/health/mmr-immunisation

www.facebook.com/GetVaccinatedEngland for FAQs on measles

### *What to do if you suspect measles in your GP surgery:*

1. Collect the following information:

Demographic details incl whether they are a member of hard to reach groups such as travellers; school or nursery; clinical information including length of prodrome, date of onset of rash, immunisation history, any known contact or recent travel inside and outside UK.

2. Call the PHE Health Protection Team (formerly HPU) on 0207 811 7100 (for north and east London. Insert post code on old HPA website to find your local PHE HPT)
3. The HPT staff will decide jointly with you whether this is a *likely* or *unlikely* case. (This guides what diagnostic tests and contact tracing are necessary.)
4. Do not send the patient to hospital unless seriously unwell

About 18% of cases so far this year have needed hospital admission. Further viral testing is done in these cases.

**NB: this is a notifiable disease and you must inform the Health Protection Team on 0207 811 7100 of all suspected cases.**

The Health Protection Agency became Public Health England (PHE) on 1st April 2013 but the pathway and phone number is the same. Full guidance for measles including what to do with school and nursery outbreaks at http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1274088429847.

### Teen why weight!

Click here for a poster to display in health centres

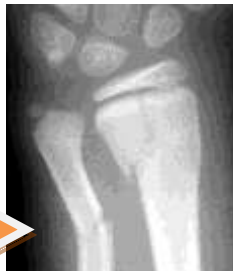
- ☑ a weight management programme for teenagers in Outer North East London
- ☑ run by community dieticians, 1 hour a week for 4 weeks
- ☑ call 0208 430 8096. Patients can self refer. No website currently.

### Go for it!

- ☑ Similar group for 4-6 and 7-12 year olds and their families. 10 week course.

Click here for 2013 list of physical activity opportunities in Waltham Forest.

## Dr Jess Spedding's Minor Injuries Series
## Episode 4: wrist injuries



Salter-Harris Type II injury - the fracture is through the metaphysis of the radius and extends to the growth plate but does not extend into the epiphysis (note also the angulated fracture of the distal ulna) – these should all be discussed with orthopaedics as many will need operative management to produce the best outcome.

Think:

1. does the mechanism fit with the history and the child's developmental stage? Always consider non accidental injury
2. does the bony injury affect the growing bone – ie. is there a fracture through the growth plate of a bone?
3. will the child tolerate the normal management?
   → most young children would not find manipulation of a fracture using entonox and iv analgesia or a 'haematoma block' (injecting local anaesthetic directly into the fracture site) acceptable, so most requiring reduction go to theatre for manipulation under general anaesthesia
4. can we allow a greater degree of angulation of a fracture because a young child's bone will remodel better than an adult's?

Assess the whole limb all the way up to the clavicle and check distal neurovascular status (pulses, capillary refill time in fingertips and sensation of radial, median and ulnar nerves). Your decision to x-ray will be based on any signs of swelling/ deformity/ bruising, or significant tenderness or neurovascular deficit. Standard views are AP (anteroposterior) and lateral.

Jess' whole, very comprehensive, article available for download by clicking here.

## Focus on: **Disorders of initiating and maintaining sleep (DIMS)**

- Group of disorders characterised by symptoms of insomnia which may result in *delayed sleep onset, bedtime refusal, prolonged and recurrent night time waking and complaints of non restorative sleep*.
- Mainly affects toddlers and pre-school children who are dealing with developmental issues such as separation anxiety or response to an acute stressful event
- •• ***Sleep onset type***: Difficulty initiating sleep independently and reliance on certain comforts e.g. place (parents' bed), specific person's presence or activity (e.g. bottle feed). Child may become used to being settled to sleep in a particular way and cannot initiate sleep without it. Then, when waking in the night, child unable to sleep again until the same sleep-inducing action is used.
- •• ***Limit setting type***: Parents struggle to set boundaries. Children use distraction/delaying techniques to delay bed-time e.g. 'one more story'

**Overall management**:

- Assess for concurrent medical, psychiatric, developmental and social problems
- Treatment centred around good 'sleep hygiene'. Review napping
- Behavioural intervention is the mainstay of treatment (+/- medications)
- Set firm limits reinforced with rewards, fixed and predictable bedtime routine
- Encourage a technique so child can learn to self soothe if s/he wakes e.g. soft toy
- Key component to success is parental consistency

Professional reference: http://www.patient.co.uk/doctor/Sleep-Problems-in-Children.htm
http://www.rcpsych.ac.uk/expertadvice/parentsandyouthinfo/parentscarers/sleepproblems.aspx for parent information on sleep disorders.
The comments posted after http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/sleep-problems-in-children.aspx prove what a sensitive topic sleep can be. What suits some families does not work for everyone!

**Next month: Parasomnias** –with thanks to Dr Sophia Datsopoulos and Professor Paul Gringras for these paediatric sleep articles.