

Paediatric Pearls

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

Stammering and Stuttering (Dysfluency)

With thanks to Dr Harriet Clompus and Louise Parker, Waltham Forest interim lead for Speech and Language Therapy

"I think that the worst part of being a stutterer is giving the impression that I'm unable to converse, that what I say doesn't really make sense anyway... The person I'm talking to starts fidgeting, and as I pray internally – 'No, don't look away' – a familiar feeling of despair arises...." *Guardian Weekend 7th July 2012, What I'm really thinking – The Stutterer*

5% of children stammer, boys more than girls. It occurs as speech becomes more complex in 3 or 4 year olds on a background of normal language development up until then.

Stammering persists into adulthood in 1 case in 5. Referral within 1 year of its onset reduces its persistence. More links and information on stammering and on referral pathways within NELFT at <http://www.paediatricpearls.co.uk/2012/08/stammering-stuttering-and-dysfluency-services/>.

Did you know that 20% of under 5 year olds can open a child resistant Cap? (3rd edition APLS manual)

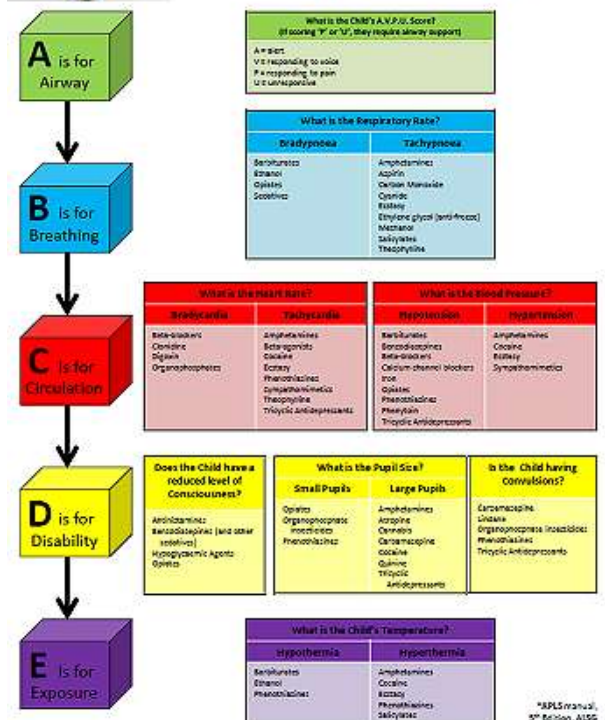
The Advanced Paediatric Life Support manual has a very dry chapter on poisoning listing the signs a child may have if they have taken a specific poison or drug overdose. In reality we don't tend to know what they have taken. I asked Dr Fran Blackburn to turn the information around and put together an Aide Memoire of possible poisons according to the signs we see. [Click here](#) for her full size document which I think deserves to be displayed in every paediatric resus area.



Poisoning in Children

Did you know that 20% of under 5 year olds can open a child-resistant cap?*

When a child presents with suspected poisoning, an ABCDE approach is helpful in the initial assessment and management. This stepwise approach can also give you clues in the identification of the possible culprit toxin(s).



When to consider pneumonia

Persistent fever > 38.5°C + chest recessions + tachypnoea

"How do children with community acquired pneumonia (CAP) present?"

Children with CAP may present with fever, tachypnoea, breathlessness or difficulty in breathing, cough, wheeze or chest pain. They may also present with abdominal pain and/or vomiting and may have headache. Children with upper respiratory tract infection and generalised wheeze with low-grade fever do not have pneumonia." **BTS 2011 update on community acquired pneumonia in children** (<http://www.brit-thoracic.org.uk/guidelines/pneumonia-guidelines.aspx>).

Dr Mike Eyre has recently audited our management of pneumonia as part of the BTS national audit. His full summary of the 2011 guidance is available on the blog [here](#). Do leave comments. Salient points:

- ◆ CXR should not be considered routine. Not required in children who do not need admission.
- ◆ Acute phase reactants including CRP are not useful in distinguishing viral from bacterial infection and should not be tested routinely. Blood cultures do not need to be routinely taken.
- ◆ Children with oxygen saturations <92% need O₂ and hospital referral.
- ◆ Children with absent breath sounds on auscultation with dullness to percussion need referral.
- ◆ Give parents information on managing fever, preventing dehydration and identifying deterioration.
- ◆ NG tubes should be avoided in severe respiratory compromise and in infants.
- ◆ Chest physio is not beneficial and should not be performed in pneumonia.
- ◆ All children with a clear clinical diagnosis of pneumonia should receive antibiotics as bacterial and viral infections cannot be reliably distinguished. However most children ≤ 2 years presenting with mild symptoms of respiratory distress do not usually require antibiotics.
- ◆ Amoxicillin is the oral first-line for all children as it is effective, well tolerated and cheap.
- ◆ Macrolides if no response to first-line / suspected mycoplasma or Chlamydia/ severe disease.
- ◆ Augmentin if pneumonia associated with influenza.
- ◆ Oral agents are effective even in severe pneumonia; IV is needed only if unable to tolerate oral or there are signs of septicaemia, empyema or abscess.

Fractures in Children – NAI or not?

Click [here](#) for the Cardiff based Core Info/NSPCC 2010 leaflet on fractures in children. It summarises what is currently known about the relationship between fractures and physical abuse.

- ☒ Accidental fractures (#) are common in children: up to 66% of boys and 40% of girls will have had one by their 15th birthday.
- ☒ #s occur in up to 25% of physically abused children. 80% of these in children <18/12.
- ☒ Any bone can be broken as a result of child abuse; many abusive #s are not clinically obvious especially in the under 2s.
- ☒ #s, particularly of ribs, may not be accompanied by bruising. Rib #s are highly indicative of abuse in children who have not been in a major accident.
- ☒ Paediatricians will arrange a skeletal survey for all children < 2 yrs where there is a suspicion of abusive #s. A repeat skeletal survey 11 to 14 days later may show healing #s not originally visible. Radiologists can estimate the age of a # in weeks, not days.
- ☒ A femoral # in a non-ambulant child can be suggestive of abuse. A spiral # is the commonest # of the femur in abused children < 15 months; in all other age groups, a transverse # is the commonest accidental or abusive femoral #.
- ☒ Metaphyseal #s in very young children are more likely to be due to abuse than to accidental causes. ([Click here](#) if you need a reminder of what the different fractures look like.)
- ☒ A spiral or oblique # of the humerus is more likely to be due to abuse than accident in a child < 15 months, but a supracondylar # is highly suggestive of accidental injury.
- ☒ In infants, it is difficult to distinguish accidental from abusive skull #s because the commonest type from both causes is a simple linear #.
- ☒ Please refer to paediatricians:
 - ☑ all children under 18 months with a #
 - ☑ all children whose # is inconsistent with their developmental stage
 - ☑ all with multiple #s, particularly of different ages
 - ☑ all #s without an adequate explanation

Junior paediatricians – please discuss all these cases with the on-call consultant.