Paediatric Pearls

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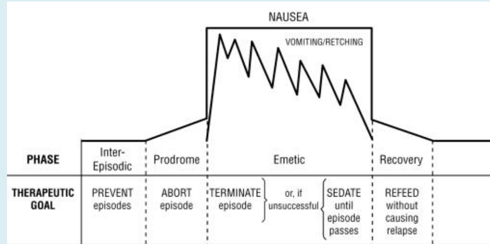
Previous editions are all available at www.paediatricpearls.co.uk

Cyclical vomiting

A. At least 5 attacks fulfilling criteria B-E
B. Episodic attacks of nausea and vomiting lasting between 1 hour and 5 days
C. Attacks of vomiting occurring at least 4 times per hour for at least 1 hour
D. Symptom free between attacks
E. Not attributed to any other disorder

Family history of migraine is likely but not necessary for diagnosis. CV may evolve into migraine.



Schematic representation of the four phases of Cyclic Vomiting Syndrome and their therapeutic goals. Fleisher *et al. BMC Medicine* 2005 **3**:20 doi:10.1186/1741-7015-3-20

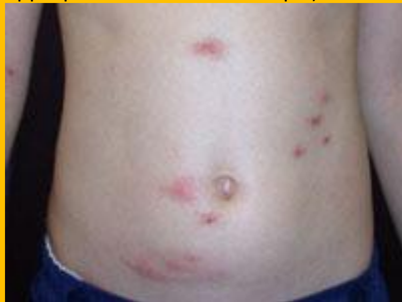
Li BUK et al. North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition Consensus Statement on the Diagnosis and Management of Cyclic Vomiting Syndrome. *Journal of Pediatric Gastroenterology and Nutrition* 2008;**47**:379–393 (full text, doses etc.)

Possibly 2% of school children affected, onset usually aged 3-7 years. F>M, can persist for months to decades. Adult onset recognised. Episode triggers include physical, emotional stress, anaesthetics, excitement, viruses, unknown. Differentials may include raised ICP and metabolic disorders (see reference above for diagnostic approach).

Prevention of episode is primary goal (avoid triggers and tiredness).
Abortion of episode may be possible if prodrome recognised (anxiolytic + antiemetic – sublingually or as a suppository helpful).
Terminating emetic phase helped by lorazepam, hyperhydration and ondansetron (see link to Li paper above), preferably in a darkened room.
Refeed in recovery phase.

The Cyclical Vomiting Support group@ www.cvsa.org.uk has parent/patient info leaflets in a number of languages and one specifically for schools. Draft patient held health record also available.

Dermatology – insect bites (with thanks to Dr Andrew Lock for this appropriate summer time topic)



Any insect bite can lead to a local cutaneous reaction, and the magnitude depends on an individual's sensitivity

Venomous insects eg. Bees, wasps – cause pain/redness/swelling at the site

Non venomous insects eg. fleas, mosquitoes – cause itching. A red spot appears which may blister or become excoriated.

Distribution can be important: Lesions are often grouped, occurring mainly on exposed sites. Some patients can develop large blisters or bullae.

Management advice to reduce itching / scratching and risk of infection

1. Some patients find calamine lotion soothing
2. Topical steroid ointments applied twice daily for several days can help relieve itching
3. Oral antihistamines may give added benefit

See this link for some good pictures:http://dermnetnz.org/arthropods/bites.html

NB. Bites can trigger a "papular urticaria" involving widespread and longer lasting oedematous/itchy papules. (http://dermnetnz.org/arthropods/papular-urticaria.html)

WELCOME to the new FY doctors and GP trainees who have just rotated

www.paediatricpearls.co.uk was set up in 2010 to house the monthly paediatric updates written to help keep all health professionals working with children up to date in all things paediatric. Many experts and trainees have contributed to it over the last 4 years. Please do browse through it or look up individual topics using the search function or tag cloud. It is all freely provided as food for thought with links to national guidelines as appropriate. Comments, questions, suggestions are welcomed on the site and please let me know if you want to contribute!

We are into autumn next month and the concomitant increase in

wheezy episodes and acute exacerbations of asthma.

Written personalised asthma action plans are recommended as part of patient education and self-management. They should form standard care for all people with asthma and should always be offered following inpatient admission for asthma. Despite clear BTS/SIGN recommendation (http://www.sign.ac.uk/pdf/qrg101.pdf), a 2007 Scottish survey showed only 23% of asthmatic patients received an action plan compared with 67% receiving the correct add-on therapy. [www.patient.co.uk/doctor/asthma-action-plans]

Children's asthma plans (separate one for the under 5s) can be downloaded from http://www.asthma.org.uk/advice-asthma-and-me and should be filled in by the health professional with the family.

"Do not do recommendations" from NICE:

During the process of guidance development NICE's independent advisory bodies often identify NHS clinical practices that they recommend should be discontinued completely or should not be used routinely. This may be due to evidence that the practice is not on balance beneficial or a lack of evidence to support its continued use. I will be including some of their "do not do recommendations" from various guidelines relevant to paediatrics in the newsletter over the next 3 or 4 months:

From **Urinary tract infection in children** (CG54). Published August 2007:

- Asymptomatic bacteriuria in infants and children should not be treated with antibiotics.
- Antibiotic prophylaxis should not be routinely recommended in infants and children following first-time urinary tract infection (UTI).
- Infants and children who do not undergo imaging investigations should not routinely be followed up.
- Infants and children who are asymptomatic following an episode of urinary tract infection (UTI) should not routinely have their urine re-tested for infection.
- Urine-testing strategies for children 3 years or older: If leukocyte esterase is positive and nitrite is negative, a urine sample should be sent for microscopy and culture. Antibiotic treatment for urinary tract infection UTI should not be started unless there is good clinical evidence of UTI for example, obvious urinary symptoms. Leukocyte esterase may be indicative of an infection outside the urinary tract which may need to be managed differently.

From **Attention deficit hyperactivity disorder** (CG72) Published September 2008

- Primary care practitioners should not make the initial diagnosis or start drug treatment in children or young people with suspected attention deficit hyperactivity disorder (ADHD).
- Drug treatment is not recommended for pre-school children with attention deficit hyperactivity disorder (ADHD).

https://www.nice.org.uk/media/default/sharedlearning/716_716donotdobookletfinal.pdf is a list of some of NICE's "do not do" recommendations (adult mainly), put together by Nottinghamshire Healthcare NHS Trust in December 2013.