

Paediatric Pearls

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

Scabies by Dr Andrew Lock, dermatology SpR. The *Sarcoptes scabiei* mite is spread by close/direct contact. It is not spread by pets.

✦ **Important symptoms:** Itch, worse at night (delayed type 4 hypersensitivity reaction to faeces, eggs, mites). Symptoms start several weeks after primary infestation (although only days if re-infestation)

✦ **Rash: generalized, composed of:** Simple excoriations; erythematous papules: trunk, groins, genitalia, axillae; burrows: thin, serpiginous red/grey lines, 2-10mm in length. Usually on sides of fingers, web spaces, wrists, feet

✦ **Specific signs in young children and infants:** Widespread eczematous areas on the trunk, vesicles/papules/pustules appearing on the palms and soles, face/neck involvement (unlike in adults).

Images, treatment and further information and resources [HERE](#).

Child trafficking is the recruitment and movement of children for the purpose of exploitation. It is child abuse. Approximately 300 victims of child trafficking are identified per year in the UK. Many more probably go under the radar. Children are moved from every part of the world (40% from Asia in 2007, 34% from Africa and 23% from Europe) to the UK for domestic and economic servitude (e.g. nail bars and agricultural work), criminal exploitation (e.g. cannabis cultivation, pick pocketing, moving drugs), benefit fraud (e.g. private fostering arrangements) and/or sexual exploitation, including forced marriage. The Children Act 1989 and 2004 applies to all children who need protection and who are physically in the UK – not just legally resident children. Trafficked children suffer from neglect, emotional, physical and sexual abuse. Suspicions should be aroused in children of school age who do not speak English, do not speak in a consultation, are not registered with educational or health services or where the relationship with the accompanying adult is unclear.

If you have concerns or for more information and training packages, contact the NSPCC child trafficking advice Centre on (0808) 800 5000 or email help@nspcc.org.uk.

We missed out the last episode of the 2013 sleep series (because the author, Dr Sophia Datsopoulos, was busy getting married... congratulations Sophia!). Here is the final part on **Somnambulism (sleep walking) and Somniloquy (sleep talking):**

Parasomnias occurring early in the night, during non-REM sleep, occur in 5-15% of school-aged children, M>F. The cause is unknown but both are exacerbated by sleep deprivation, fatigue and stress/anxiety, and are usually outgrown by adolescence. Majority of episodes last under 10 minutes and are not recalled on waking. No specific investigations are necessary. Exclude complex partial seizures by thorough history taking.

Somnambulism (sleepwalking) - A child sits up in bed with eyes open but is "unseeing". Activity may range from a purposeless restlessness in bed, to mobilisation around the house. On occasion, they may engage in inappropriate activities e.g. urinating in cupboards. If woken during an episode, children appear confused. Sleepwalkers have the potential for physical harm, and parents must take steps to avoid unsafe situations.

Somniloquy – When sleep-talking, the child's voice and type of language used may sound different from their wakeful speech. The lighter the sleep, the more intelligible the speech. Sleep talking may be spontaneous or induced by conversation with the sleeper.

Management

- ✦ Generally, no intervention is needed other than reassurance. Pharmacological intervention is not indicated.
- ✦ Consider safety around the house e.g. keeping windows/doors locked and the consideration of stair-gates.
- ✦ Address any environmental or predisposing factors e.g. fatigue or stress
- ✦ Confronting and waking a sleepwalker may not be necessary; it may be possible to comfort and redirect them to bed; they are in a very deep sleep and may become confused or, rarely, aggressive if confronted.
- ✦ Some children respond well to scheduled awakenings; parents wake the child up 15 minutes before usual sleepwalking onset time, and keep them awake for at least five minutes. Using this technique, sleepwalking may resolve in >80%.
- ✦ Siblings or family sharing a bedroom with a sleep-talker may consider earplugs or white noise (such as a fan)
- ✦ TFTs may be considered in children out of the usual age-range for parasomnias - a link with hyperthyroidism has been suggested.

www.sleepfoundation.org is a useful website with links to information leaflets and information on a wide range of paediatric and adult sleep disorders.

Updated NICE guideline: Triage, assessment, investigation and early management of head injury in children, young people and adults. January 2014 www.guidance.nice.org.uk/cq176

Each year, 1.4 million people attend EDs in England and Wales with a recent head injury. 33% - 50% of these are children < 15 years. Mortality is very low at 0.2% (particularly rare in people presenting with GCS >12). In 25-30% of children < 2 with a head injury the cause is abusive.

Perform a **CT head within 1 hour** if:

- ✦ Suspicion of NAI
- ✦ Post-traumatic seizure but no history of epilepsy
- ✦ GCS < 14 at presentation or <15 at 2 hours, or for children under 1 year GCS (paediatric) < 15 on presentation
- ✦ Suspected open or depressed skull fracture or tense fontanelle
- ✦ Any sign of basal skull fracture (haemotympanum, 'panda' eyes ([picture here](#)), CSF leakage from the ear or nose, Battle's sign ([click for picture](#)))
- ✦ Focal neurological deficit
- ✦ < 1 year, with a bruise, swelling or laceration > 5cm on the head

Also CT those with **more than one** of the following:

- ✦ Loss of consciousness lasting more than 5 minutes (witnessed)
- ✦ Abnormal drowsiness
- ✦ Three or more discrete episodes of vomiting
- ✦ Dangerous mechanism of injury
- ✦ Amnesia (antegrade or retrograde) lasting more than 5 minutes.

[Click here for the updated algorithms](#) for adults and children on head and cervical spine imaging. Those with just 1 of these risk factors should be observed for **4 hours**. Patients should have verbal and printed discharge advice though unfortunately NICE currently only provides an [advice sheet suitable for >16yr](#) olds who have sustained a head injury. Try this sensible [Australian one](#) as an alternative.

I have uploaded some excellent new additions to the [primary care guidelines page](#), with thanks to Drs Rachel Casey (GP), Dr Raman Lakshman (paediatrician, West Suffolk hospital) and Hannah Neumann-May (project manager, West Suffolk CCG). **Asthma** assessment and management guides, one of which will be useful for children going home from the ED too. Also a helpful 1 page summary on **GORD** and a succinct reminder of the updated NICE **fever traffic light** system including guidelines for remote assessors.

Dr Tom Waterfield asks: Do antipyretics prevent febrile convulsions?

Febrile convulsions are common in the UK affecting 2-4% of children. They typically occur in children aged between 6 months and 6 years and there may be a family history. The condition is typically benign with most children growing out of it; **there is no link between simple febrile convulsions and epilepsy.**

Despite this however, febrile convulsions remain a source of significant parental anxiety and I was reminded of this earlier in the week when a parent explained how they had been giving their child regular paracetamol during a recent viral illness to prevent a febrile convulsion. So how effective is this strategy?

A Cochrane review published in April 2012 combined data from 36 studies (26 randomised) including 2740 children over 45 years and found no benefit of antipyretics (Paracetamol/Ibuprofen) (1). A further meta-analysis of three studies (540 patients) published earlier this year in the European Journal of Paediatric Neurology again found no statistically significant effect of antipyretic prophylaxis on the recurrence rates of febrile convulsions (2).

Prophylactic antipyretic medications have no role in the management of febrile convulsions and parents should be reassured with regards to the benign nature of the illness and given basic first aid advice. **As doctors we should not recommend prophylactic antipyretic medication for the prevention of febrile convulsions.**

1. Offringa M, Newton R. Prophylactic drug management for febrile seizures in children. Cochrane Database Syst Rev. 2012 Apr 18;4:CD003031.

2. Rosenbloom E, Finkelstein Y, Adams-Webster T, Kozer E. Do antipyretics prevent the recurrence of febrile seizures in children? A systematic review of randomized controlled trials and meta-analysis. Eur J Paediatr Neurol. 2013 May 21. pii: S1090-3798(13)00065-2.

Sensible parent information leaflet on febrile convulsions at: <http://www.patient.co.uk/health/febrile-seizure-febrile-convulsion>