

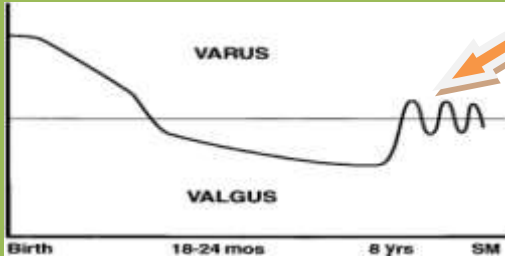


Paediatric Pearls

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



Knock knees (Valgus) and bow legs (Varus)

The graph shows the physiological progression of varus to valgus in the growing child. By the time they are 8 their legs should be straight or take on a slight, usually familial, varus or valgus. Very early walkers may have more marked varus which may persist to age 3. Consider rickets in our region of endemic [Vitamin D deficiency](#) in the differential. If varus persists beyond age 3 consider [Blount's disease](#) and refer to paediatric orthopaedic surgeons (available locally at Royal London Hospital). Parent information on common childhood orthopaedic problems at http://kidshealth.org/parent/medical/bones/common_ortho.html#.

NEW asthma leaflets

The Scottish Intercollegiate Guidelines Network (SIGN) have produced comprehensive patient information leaflets on asthma. Click [here](#) for the children's one which has some good links and pictures in it. Based on the full BTS/SIGN 2011 asthma guideline available at www.sign.ac.uk/pdf/sign101.pdf.

This month we welcomed **Dr Su Li** to the paediatric consultant body at Whipps Cross.

Like me, she has clinical duties within the paediatric ED as well as working as a general paediatrician. This means that, with Dr Kausikh Nandi as well (who is purely A and E based), there are now 3 senior paediatricians in and around the paediatric ED. As well as our clinical and training commitments, we are working closely with the Urgent Care Centre on the development of robust paediatric pathways and welcome calls for clinical advice from EUCC GPs or ENPs.

Please note that the GP advisory line is also still running; call the hospital Monday to Friday between 11am and 1pm and ask to speak to the "attending paediatric consultant". Definite urgent referrals from community GPs need to be phoned through to the on-call paediatric registrar please in the usual way. Sending them with a letter is not enough!

BSACI* guidelines

for the management of egg allergy

[CLICK HERE](#) for full text of 2010 guideline

(includes patient information sheet on egg allergy and a guideline for those with mild egg allergy on how to reintroduce egg at home)

- Egg allergy is common: 2% prevalence amongst children
- Usually presents with urticaria +/- angio-oedema within minutes of first exposure
- Very rare cause of anaphylaxis though asthma makes risk higher
- Diagnosed on history and either skin prick testing (SPT) or specific IgE but SPT has poor specificity and there are no agreed values for IgE in different age groups
- Cornerstone of management is **avoid egg**. Might tolerate baked egg in cakes, biscuits etc.
- Families should have oral antihistamine handy but only need an adrenaline auto-injector if they have asthma or have had a reaction to egg involving airway narrowing
- Do not attempt reintroduction of egg within 6 months of reaction
- If reaction was mild home reintroduction is appropriate (see guideline appendix for how to do it). If reaction was severe or child has asthma then reintroduction should be done by specialist team.
- Majority resolve before age 6-8
- Associated with an increased risk of asthma and other food allergies (especially nuts) in later childhood
- MMR vaccine is safe to give in the community to egg allergic children
- Influenza and yellow fever vaccines are more likely to cause an allergic reaction so refer children who need those immunisations to an allergy service

Did you know that [chewits and creme eggs](#) contain egg?

* British Society for allergy and clinical immunology (www.bsaci.org)

CG47 on **Feverish illness in children** is currently in the process of being reviewed. NICE publishes "do not do recommendations" for each of its clinical guidelines and one of them for [CG47 is not to give paracetamol and ibuprofen at the same time](#). Dr Raj Kainth has looked at 2 recent articles on this subject from Archives of Disease in Childhood ([click here](#)). It seems that the advice remains the same; there is no evidence that giving them together has any benefit that outweighs the risk of overdose and the risk of increasing parental "fear of fever".

Other "do not do recommendations" from this guideline include:

- [Children with pneumonia clinically, not requiring hospital admission, should not have a chest x-ray](#)
- [Oral antibiotics should not be prescribed if there is no identified source of fever](#)
- [Do not do blood tests on feverish children with no features of serious illness](#)
- [Antipyretic agents do not prevent febrile convulsions and should not be used solely for that purpose](#)
- [Tepid sponging is not recommended](#)
- [Take the parents views into account but treat the child, not the temperature per se](#)

What is the difference between myoclonic epilepsy and benign neonatal sleep myoclonus?

Benign neonatal sleep myoclonus is characterized by myoclonic "lightninglike" jerks of the extremities that exclusively occur during sleep; it is not correlated with epilepsy. There is a good overview at <http://emedicine.medscape.com/article/1355567-overview#a0101> and a full text review at <http://pediatrics.aappublications.org/content/125/4/e919.full>

- ♦ Neonatal onset (in first 2 weeks of life)
- ♦ Myoclonic jerks occur only during drowsiness or sleep and cease with arousal
- ♦ No signs of epileptiform paroxysmal activity on EEG if performed
- ♦ Most, but not all, resolve by 3 months of age

The diagnosis is usually made on clinical grounds only, unnecessary investigations may blur the picture and inappropriate medication can make the myoclonus worse.

The **myoclonic epilepsies** may not be so benign. They rarely present before 3 months and seizures will occur during periods of wakefulness as well. There are EEG changes. See overview at <http://emedicine.medscape.com/article/1176055-overview>.