

Paediatric Pearls

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

Faddy eating, food refusal, portion sizes, vegetarian diets, tooth decay, iron deficiency, vitamin D, food hypersensitivity, constipation.....

Is there a GP, HV or paediatrician around who does not deal with these issues? I can not recommend www.infantandtoddlerforum.org enough! It covers every question a parent has ever asked you and has downloadable advice sheets for parents and healthcare professionals. Here's a copy of a small part of the one on "How to manage simple faddy eating in toddlers".

Do	Reason
1. Eat with your child as often as possible.	1. Toddlers learn by copying their parents and other children.
2. Develop a daily routine of three meals and two to three snacks around your toddler's sleeping pattern.	2. Toddlers don't eat well if they become over hungry or very tired.
3. Offer two courses at meals: one savoury course followed by a sweet course.	3. This gives two opportunities for the toddler to take in the calories and nutrients needed and offers a wider variety of foods. It also makes the meal more interesting.
4. Praise toddlers when they eat well.	4. Toddlers respond positively to praise.
5. Make positive comments about the food.	5. Parents and carers are strong role models. If you make positive comments about foods, toddlers will be more willing to try them.
6. Arrange for toddlers to eat with other toddlers as often as possible	6. Some toddlers eat better when they are with their own age group.
7. Give small portions. If these are finished, praise the toddler and offer more.	7. Toddlers can be overwhelmed by large portions and lose their appetite.
8. Offer finger foods as often as possible.	8. Toddlers enjoy having the control of feeding themselves with finger foods.
9. Eat in a calm, relaxed environment without distractions such as TV, games and toys.	9. Toddlers concentrate on one thing at a time. Distractions make it more difficult to concentrate on eating.
10. Finish the meal within about 20-30 minutes and accept that after this the toddler is not going to eat any more.	10. Carrying the meal on for too long is unlikely to result in the toddler eating much more. It is better to wait for the next snack or meal and offer nutritious foods then.

We all need to do a bit better with managing **ATOPIC ECZEMA**.....

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. [QS44](#) was issued in September 2013 and is based on the 2007 Clinical Guideline on **atopic eczema in children** up to the age of 12. It has been incorporated into the [NICE clinical pathway](#) on management of atopic eczema in children.

List of quality statements ([audit tool](#) available and [guidance on commissioning](#)):

Statement 1. Children with atopic eczema are offered, at diagnosis, an assessment that includes recording of their detailed clinical and treatment histories and identification of potential trigger factors.

Statement 2. Children with atopic eczema are offered treatment based on recorded eczema severity using the stepped-care plan, supported by education.

Statement 3. Children with atopic eczema have their (and their families') psychological wellbeing and quality of life discussed and recorded at each eczema consultation.

Statement 4. Children with atopic eczema are prescribed sufficient quantities (250–500 g weekly) from a choice of unperfumed emollients for daily use.

Statement 5. Children with uncontrolled or unresponsive atopic eczema, including recurring infections, or psychosocial problems related to the atopic eczema are referred for specialist dermatological advice.

Statement 6. Infants and young children with moderate or severe atopic eczema that has not been controlled by optimal treatment are referred for specialist investigation to identify possible food and other allergies.

Statement 7. Children with atopic eczema who have suspected eczema herpeticum receive immediate treatment with systemic aciclovir and are referred for same-day specialist dermatological advice.

E-learning on eczema at elearning.bmj.com (basic) and "[difficult and severe eczema](#)" module.

>90% of patients with moderate-severe atopic dermatitis are colonised by staphylococcus (<http://nationaleczema.org>). No need to swab unless resistance suspected. Treat localised bacterial infection with topical antibiotics eg. Fucidin H for up to 2 weeks. Systemic infections also need 2 weeks of treatment. Flucloxacillin (or erythromycin in allergic individuals) is first line. Chlorhexidine wash is a good idea in recurrent infected eczema but not long term. **Don't stop the steroids and emollients during acute infections.**

Suturing: Aware that most of this month's issue is more relevant to primary care than emergency medicine, I include a [link to a video on basic suturing](#) for new ED doctors. If you are offended by the pig trotter he uses for demonstration, try an alternative video on suturing bananas at <http://www.youtube.com/watch?v=Jix6-EFtCo>.

With thanks to Dr Andrew Lock, dermatology registrar at the Royal London Hospital, London, UK

Approximately 15% of GP consultations involve dermatological problems. Many doctors lack confidence in the diagnosis and management of skin conditions and little time is allocated to dermatology at medical school. In a monthly series on dermatological conditions, the following topics will be covered:

- Scabies
- Fungal infections (tinea)
- Viral warts/verrucae
- Acne
- Insect bites
- Urticaria
- Pityriasis rosea
- Psoriasis
- Molluscum contagiosum



The series begins in February with **Scabies!**

In the meantime, why not check out these useful online resources?

www.bad.org.uk
www.dermnetnz.org

New series!
Dermatology

Dr Tom Waterfield's "From the Literature" slot

Medication for Attention Deficit–Hyperactivity Disorder and Criminality: Paul Lichtenstein et al. *N Engl J Med* 2012; 367:2006-2014 November 22, 2012 DOI: 10.1056/NEJMoa1203241.

ADHD is an increasingly recognised problem and it has been estimated that 5% of children meet ICD-10 criteria for ADHD. Clinicians are becoming increasingly comfortable managing ADHD in children and there are now clear NICE guidelines outlining standards of care (<http://guidance.nice.org.uk/CG72>). There is however, debate over the risks/benefits of lifelong use of ADHD medication. A Swedish population linkage study published in November 2012 looked at ADHD in 25,656 patients (16,087 men and 9569 women) who met either ICD-9 or ICD-10 diagnostic criteria depending on the year of diagnosis.

The study demonstrated that individuals on ADHD medication were less like to be convicted for criminal behaviour than those not taking medication (Hazard ratios 0.7 in men and 0.78 in women). Furthermore to try and exclude bias from confounders they performed a within-patient analysis where they looked at the risk of criminality within the same patient during periods either on or off medication and again they found a reduced risk during medication periods (Hazard ratios of 0.68 (men) and 0.59 (women), P<0.001 for both). The results were the same irrespective of the medication used.

This information is useful when considering the discontinuation of ADHD medications in adolescents and adults; especially if there is a history of criminal behaviour. **It would appear that simply continuing ADHD medication reduces the risk of criminality by around 30-40%.**