Paediatric Pearls

July 2015

Put together by: Dr Julia Thomson, Consultant Paediatrician, julia.thomson@bartshealth.nhs.uk

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

Paediatric drooling with thanks to Mr Sunil Sharma, ENT registrar

- problem in babies, usually settles by age 2
- Persistent, chronic drooling usually due to failure of co-ordination of muscles involved in the first stage of swallowing
- Persistent drooling can cause bullying, soiling of clothing, excretion of skin
- Ask about age of onset, chronicity, precipitating factors, severity, developmental history, medication, family history, etc.

- Causes include:
  - Physiological (e.g. teething)
  - CNS and muscular disorders (e.g. cerebral palsy, facial nerve palsy)
  - GORD
  - Lesions in the upper aero-digestive tract
  - Neurodevelopmental delay
  - Medication and chemicals (e.g. morphine, mercury)
  - Genetic conditions (e.g. Wilson’s disease, Riley-Day syndrome)

- Management:
  - Speech therapy in all cases (please refer to local Child Development Centre)
  - Surgery only considered after the age of 5-6 years after at least 6 months of conservative management (refer to ENT at this stage)
- Surgical options include adenotonsillecetomy, bilateral submandibular duct transposition, submandibular gland excision, botox injections into salivary glands, tracheostomy, and even laryngectomy


Australian patient information leaflet:
http://www.rch.org.au/uploadedFiles/Main/Content/plastic/salivabook.pdf

Paediatric chest pain

Ask specifically about palpitations as the terms are sometimes used synonymously. Chest pain is the most common complaint in 10-15% of cases of supraventricular tachycardias.

ReD flags
Exercise induced pain +/- palpitations
Syncope
PMH of Kawasaki disease or congenital heart disease
Shortness of breath
Pain disturbing sleep / daily activities
Abnormal clinical examination
Positive family history of sudden death
Substance abuse

If referring to secondary care, Paediatrics is usually more appropriate than cardiology 6/8 of the wide differential and low likelihood of a cardiac cause

Investigations which may be of use:
- 12 lead ECG
- Chest x-ray
- 24 hour tape or event recorder
- Echocardiogram
- Baseline bloods to incl. TFTs and Hb

Common cause for worry: referral and discussion of physical activity yet only 0.6 - 4% of chest pain in children is cardiac.

- Musculoskeletal: 25-55%
- Respiratory: 9-20%
- Iatrogenic: 15-25%
- Psychogenic: 1-5%
- Cardiolosthenia: 3-6%


- Covers recognition of early signs of cancer in children and adults in an attempt to improve survival.
- Unfortunately lists early signs by site of cancer so purely paediatric practitioners need to trawl through a lot of information on adults to find relevant information. A more useful “childhood cancers infographic” which summarises worrying signs and symptoms in children was put together for the BMI and is available from http://www.bmj.com/content/350/bmj.h3036.

Leukaemia: refer immediately for unexplained petechiae or hepatosplenomegaly. Do FBC within 48 hours for unexplained pallor, persistent bone pain, fatigue, bruising or bleeding.

Neuroblastoma: referral within 48 hours for child with an unexplained abdominal mass or enlarged abdominal organ

Wilms tumour: as above and for those with unexplained visible haematuria

Osteosarcoma: x-ray within 48 hours for children with unexplained bone swelling or pain

Brain tumour: immediate referral for children with abnormal cerebellar or other neurological function

Retinoblastoma: referral within 2 weeks to ophthalmology for babies with an absent red reflex

Soft tissue sarcoma: ultrasound within 48 hours of unexplained lump that is increasing in size

Lymphoma: refer within 48 hours for unexplained lymphadenopathy or splenomegaly. Take note of any night sweats, pruritus, weight loss, fever, shortness of breath.

- Take into account the insight and knowledge of parents and consider referral where there are persistent signs or concerns even if the likely cause of their child’s symptoms is benign.