

Paediatric Pearls

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

[Working Together to Safeguard Children](#) was updated in March 2015.

Local authorities have responsibility for safeguarding and promoting the welfare of all children and young people in their area. They have a number of statutory functions under the 1989 and 2004 Children Acts which make this clear, and this guidance sets these out in detail. It also serves as a guide to interagency working as safeguarding children is the business of all of us.

All relevant professionals should read and follow this guidance so that they can respond to individual children's needs appropriately.

A version of the guidance for [young people](#) and a separate version suitable for [younger children](#) are also available for practitioners to share.

In 2013-14 over 650,000 children in England were referred to local authority children's social care services by individuals who had concerns about their welfare.

For services to be effective they should be based on a clear understanding of the needs and views of children (see inset box).

Children have said that they need:

- **Vigilance:** to have adults notice when things are troubling them
- **Understanding and action:** to understand what is happening; to be heard and understood; and to have that understanding acted upon
- **Stability:** to be able to develop an on-going stable relationship of trust with those helping them
- **Respect:** to be treated with the expectation that they are competent rather than not
- **Information and engagement:** to be informed about and involved in procedures, decisions, concerns and plans
- **Explanation:** to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
- **Support:** to be provided with support in their own right as well as a member of their family
- **Advocacy:** to be provided with advocacy to assist them in putting forward their views

Viral exanthems by Dr Andrew Lock (link to [whole PDF here](#))

1. Roseola infantum (see [January 2015](#) newsletter)
2. Pityriasis rosea (see [February 2015](#) newsletter)
3. Chickenpox (see [March 2015](#) newsletter)
4. Erythema infectiosum (see [April 2015](#))
5. Hand foot and mouth (see [May 2015](#))
6. **Gianotti Crosti:**

- * Affects children at a mean age of 2 years (6 months – 12 years)
- * Commonly occurs in spring and summer time
- * Cutaneous response to various viral infections – EBV is thought to be most common, also Hep B virus
- * Often prodrome of respiratory symptoms and malaise
- * Monomorphic pink and red oedematous papules occur on the face, buttocks and extensor surfaces. The trunk is usually spared, and lesions can sometimes be found on the face only
- * Lesions may sometimes be purpuric or vesicular +/- fever and lymphadenopathy, which may persist for months
- * Rash fades over 2-8 weeks with mild scaling

[PHE recommended period of quarantine](#) from school/nursery: not listed

Pictures:
<http://dermnetz.org/viral/gcs-imgs.html>



Paediatric epistaxis (Mr Sunil Sharma)

- Common in paediatric population over the age of 2 years
- Ask about duration, frequency, associated symptoms, precipitating factors, bleeding disorders, easy bruising, and medications
- Retrospective review of 175 children over 8 years¹:
Most common associated symptom was nasal blockage; significant proportion of patients presenting with epistaxis will have underlying allergic rhinitis therefore important to treat this too (How? [Click here](#))
- Not necessary to do routine blood tests in children
- No role for routine imaging in children
- No role for routine flexible nasendoscopy in children. Consider if high clinical suspicion (e.g. juvenile angiofibroma, exclusively in teenage boys with history of nasal blockage and epistaxis)
- Referral to ENT should be undertaken after trial of emollient (e.g. Vaseline or naseptin (chlorhexidine and neomycin)) and review after 6-8 weeks (refer early if < 2, teenage boy with recurrent nosebleeds, concerns about underlying bleeding disorders)
- Cauterisation with silver nitrate should only be undertaken if blood vessels are visible in Little's area after nasal decongestion

¹Patel N, et al. An update on the management of paediatric epistaxis. *Int J PaedOto.* 2014;**78**:1400-1404.

Further reading and MRI picture of angiofibroma at <http://www.gponline.com/managing-epistaxis-children-paediatric-medicine/paediatrics/childhood-infections/article/1057178>

Sensible parent information including first aid advice [here](#).

Recently uploaded to the Primary Care Guidelines section of www.paediatricpearls.co.uk: ENT referral guidelines (adult and paediatric) from Hertfordshire, 2 more guidelines from West Suffolk CCG (Diarrhoea and vomiting in the under 5s and chronic abdominal pain), Redbridge Breastfeeding Cafes leaflet and Redbridge's Healthy Eating team's information on local drop in groups plus referral form. Lots of helpful guidelines and thresholds for 2^o care referral collected from across the UK available [on the site](#).

From the literature by Dr Tom Waterfield: [Understanding Imported Malaria In The UK](#)

With the summer holidays approaching there is likely to be a seasonal surge in cases of imported malaria; in this month's PP I revisit a review paper looking at how these cases present in the UK.

Background

There are three main strains of Malaria seen in humans (Falciparum, Vivax and Ovale). Falciparum Malaria is the most common form seen in the UK, is responsible for the most severe disease and accounts for almost all cases of severe Malaria in children in the UK. It is almost exclusively seen in children returning from sub-Saharan Africa. Ovale and Vivax are responsible for less severe cases of malaria and typically have a much less acute presentation.

Presentation

Children with Falciparum Malaria are more likely to develop a severe illness and are more likely to have an atypical presentation. This is because children, unlike adults, are unlikely to have any resistance or immunity meaning that they typically deteriorate more quickly. Also compliance with chemoprophylaxis is typically poorer in children with only 3-15% of children taking appropriate prophylaxis. Imported malaria cases in children peak in the summer months and over the Christmas and New Year period when families visit relatives in Sub-Saharan Africa. The children almost always present after returning home and Falciparum Malaria will usually present within one month. Children with Falciparum Malaria present with high fevers (often over 40°C), lethargy, malaise and gastrointestinal upset. They rarely present with the classical myalgia/arthralgia and less than one in four children have the classical tertian or quartan fever described in adults. Children are however more likely to present with hepatomegaly (56%), splenomegaly (48%) or thrombocytopenia <150 (45-71%).

Investigation

The gold standard for Malaria diagnosis is microscopy with thin and thick films and typically three negative films are required before a diagnosis of Malaria can be excluded. A growing number of antigen tests with varying specificity and sensitivity are available and these can be used to expedite a diagnosis. In cases of suspected Malaria it is worth liaising with Public Health England early.

References:

- 1) Ladhani S, Aibara R, Riordan A, et al. Imported malaria in children: a review of clinical studies. *Lancet Infect Dis.* 2007;**7**:349-57