Paediatric Pearls

June 2014

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

Local Safeguarding Children Boards (LSCBs) were established by the Children Act 2004. It is a statutory responsibility for each locality to have this mechanism in place whereby organisations can come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. They each run a comprehensive training programme for people working with young people in their borough. Click on your borough name for your LSCB’s training page or go to your council website and search for LSCB if not listed here: Waltham Forest, Redbridge, Tower Hamlets, Hackney, Newham, Enfield, Islington, Barking and Havering, Essex.

Reminder: GPs, ED and paediatric consultants and trainees need to ensure their level 3 training is kept up to date. Click here for 2014 intercollegiate document on expected competencies.

Main features of migraine in adults and children and tension type headache

<table>
<thead>
<tr>
<th>Migraine in Adults</th>
<th>Migraine in Children</th>
<th>Tension Type Headache</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually unilateral</td>
<td>Usually bilateral</td>
<td>Usually bilateral</td>
</tr>
<tr>
<td>Moderate to severe headache</td>
<td>Mild to severe headache</td>
<td>Mild to moderate headache</td>
</tr>
<tr>
<td>Throbbing/stabbing nature of pain</td>
<td>Can take any form</td>
<td>Pressure or band-like pain</td>
</tr>
<tr>
<td>4-72 hours</td>
<td>Usually less than 4 hours</td>
<td>Variable</td>
</tr>
<tr>
<td>Associated symptoms include nausea, vomiting, photophobia or phonophobia</td>
<td>Not always present</td>
<td>No associated symptoms</td>
</tr>
</tbody>
</table>

Can be associated with an aura in 30% | Aura less common | No aura |

Frequently prevents normal activity | Frequently prevents normal activity | Sufferer usually able to continue with normal activities

Source: RCGPs school policy guideline for young people with troublesome headaches.

Dr Andrew Lock continues his dermatology series with some pointers on acne in different aged children:

- *Neonatal acne* (neonatal cephalic pustulosis). Not a “true” acne. Appears at 2 weeks in ~20% of neonates, tends to resolve at 1-3 months. Small inflamed papules/pustules on cheeks and nasal bridge (no comedones). Reseates, as will resolve. Ketoconazole 2% cream can help. Link to images: http://www.dermnetnz.org/acne/neonatal


- *Pre pubertal acne*. Acne is rare in older pre pubertal children. Investigate/refer to secondary care if signs of precocious puberty / developmental abnormalities.

PDCS Link: http://www.pcds.org.uk/clinical-guidance/pre-pubertal-acne

- *Pubertal acne*. About 15% of the adolescent population have sufficiently problematic acne to seek treatment. In most patients it clears up after about 5 years but some still have it as an adult. Early treatment helps.

PDCS summary of treatments, with good pictures: http://www.pcds.org.uk/clinical-guidance/acne-vulgaris

Important points:

- Tetracyclines should not be given < 12 years
- Efficacy of treatments should be assessed after 2-3 months
- Combining treatment modalities e.g. oral antibiotic and topical retinoid can be more effective
- Ensure patient not using occlusive cosmetic products (acne cosmetica)
- Be aware of drug induced acne e.g. steroids, lithium, phenytoin

Patient information leaflet from British Association of Dermatologists here.

Dr Tom Waterfield (inciteful as ever despite his newfound neurosis) asks: Are baby slings a risk factor for Sudden Infantile Death Syndrome (SIDS)?

I recently became a first time father and since then my son (Alexander) has turned my life upside down! In the space of two weeks I have morphed from a calm paediatrician into a neurotic and over anxious parent. I often ask myself “is he breathing too fast?”, “is he breathing too slowly?”, “what was that funny noise?” and like all parents I worry about cot death (Sudden Infantile Death Syndrome – SIDS). In the UK the Back to Sleep campaign has significantly reduced the risk of SIDS and most parents are now aware of the risks and how to avoid them1. [Link to Back To Sleep Article & Guidelines http://www.medicus.org.uk/viewarticle/781709] Like many parents we own a baby sling and Alex loves it. I was happy too until I read an article from the Telegraph on a recent profile case of SIDS attributed to suffocation secondary to the use of a baby sling2. The case was horrific and triggered the neurotic parent in me. Had I been placing Alex at risk by using a baby sling?

The calm paediatrician in me decided that a quick literature search was required. In the United States the Consumer Product Safety Commission reported a total of 14 deaths attributed to baby slings spanning a period of 20 years,12 of these deaths occurred in children under 4 months of age, “many” of the deaths occurred in babies with additional risk factors for SIDS, 3 deaths occurred in 2010 following use of Infantino baby slings. A Medline search identified three papers (all case reports/case series)10,12 two articles were only available in Spanish10, the third was a case report of two babies (both under 4 months of age) who reportedly died from suffocation after being carried in a baby sling5.

**Summary:** From what little literature there is available it would appear that death secondary to use of a baby sling is exceptionally rare. In most cases death has occurred in infants aged less than 4 months who have poor head control and are at risk of suffocation either by direct contact with sling fabric or with extreme neck flexion resulting in airway obstruction. If parents choose to use a sling then they should be encouraged to use them in children under 4 months of age and to be careful to ensure that manufacturer’s guidelines have been followed. Parents may choose not to use slings in children with additional risk factors for SIDS (Prematurity, low birth weight, intercurrent respiratory illness).

**References:** at http://www.paediatricpearls.co.uk/2014/06/do-baby-slings-cause-sids/