Paediatric Pearls

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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.

Level 1: All staff working in health care settings
Level 2: All non-clinical and clinical staff who have any contact with children, young people and/or parents/carers
Level 3: All clinical staff working with children, young people and/or their parents/carers

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

Migraine in Adults	*Migraine in Children*	*Tension Type Headache*
Usually unilateral Moderate to severe headache	Usually bilateral Mild to severe headache	Usually bilateral Mild to moderate headache
Throbbing/stabbing nature of pain	Can take any form	Pressure or band-like pain
4-72 hours	Usually less than 4 hours	Variable
Associated symptoms include nausea, vomiting, photophobia or phonophobia	Not always present	No associated symptoms
Can be associated with an aura in 30%	Aura less common	No aura
Frequently prevents normal activities	Frequently prevents normal activity	Sufferer usually able to continue with normal activities

Source: RCGP's school policy guideline for young people with troublesome headaches

NICE referral advice

Click here to access NICE's **referral to secondary care** recommendations database.

This supersedes the 2001 document called 'Referral Advice: A Guide to Appropriate Referral from Primary to Specialist Services' which is still available here. Acne is covered in the 2001 document but not the new database!

Most patients with acne can be managed in primary care. NICE advises referral if they:
✪✪✪ have a severe variant such as fulminating acne with systemic symptoms (acne fulminans)
✪✪ have severe acne or painful, deep nodules or cysts and could benefit from oral isotretinoin
✪✪ have severe social or psychological problems, including a morbid fear of deformity
✪ are at risk of, or are developing, scarring despite primary care therapies
✪ have moderate acne that has failed to respond to treatment which should generally include several courses of both topical and systemic treatment over a period of at least 6 months.
✪ are suspected of having an underlying endocrinological cause for the acne (eg. PCOS)

(✪✪✪ see within 2 weeks, ✪✪ see "soon", ✪ see routinely (NICE 2001))

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)
Reassure, as will resolve. Ketoconazole 2% cream can help. Link to images:
http://www.dermnetnz.org/acne/neonatal-cephalic-pustulosis.html

◆ "Infantile" acne
3 months – 3 years. Usually on cheeks, comedone formation is prominent.
Treatment: Topical benzoyl peroxide/erythromycin/retinoids; Oral erythromycin. If severe / nodulocystic / scarring, refer to secondary care

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

PCDS 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 them[1]. (*Link to Back To Sleep Article & Guidelines* http://www.medscape.com/viewarticle/781979_2.) 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 high profile case of SIDS attributed to suffocation secondary to the use of a baby sling[2]. 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[3], 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)[4-6], two articles were only available in Spanish [5,6], 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 sling[6]

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 over 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/