Paediatric Pearls

March 2013

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

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

BSACI guidelines for the management of allergic and non-allergic rhinitis(full text). NICE now recognises the British Society of Allergy and Clinical Immunology guidelines. This paper provides an in-depth desription of rhinitis and its management.

♦ Rhinitis describes inflammation of the nasal mucosa. Symptoms include nasal discharge, itching, sneezing and nasal blockage or congestion. It is classified into *allergic, non-allergic* and *infective*.
♦ Allergic rhinitis (AR) affects over 20% of the UK population and is the predominant form of rhinitis in children. It is diagnosed by history and examination backed up by specific allergy tests.
♦ Rhinitis a risk factor for the development of asthma and controlling rhinitis is associated with better asthma control
♦ Oral allergy syndrome is triggered in some children with AR due to cross reacting allergens in some fruits, nuts and vegetables.
♦ Management in children: non-sedating once daily oral antihistamine, topical nasal steroid, antihistamine eye drops, allergen avoidance, good technique for nasal sprays and drops (diagrams in linked paper) and good long term compliance. Start treatment 2 weeks before their season starts; children with hayfever brought on by tree pollen will start symptoms earlier in the year than those who are allergic to grass pollens. Read more.
♦ Immunotherapy is highly effective in selected cases but still not common in the UK outside of tertiary allergy centres

☑ Prophylactic *non-sedating* antihistamines are useful if the main symptoms are rhinorrhoea and sneezing, or if there are symptoms outside the nose such as conjunctivitis or rash. Eg. loratadine, cetirizine.
☑ Nasal steroids with low systemic bioavailability, eg Avamys, are useful for nasal congestion and obstruction and can be used intermittently.
☑ For seasonal allergic rhinitis (hay fever), saline nasal irrigation during the pollen season may improve symptoms and reduce antihistamine requirement.
☑ Leukotriene receptor antagonists, eg. montelukast, may have a role if there is concomitant asthma.
☑ Antihistamine eye drops, eg. optilast or olapatadine drops, reduce itching, hyperaemia, watering, chemosis and periorbital oedema often associated with allergic rhinitis.

The RCPCH has put together a clear, easy-to-follow care pathway for asthma/allergic rhinitis based on the BSACI guideline. Full text available.

Julia's personal tally of babies in the ED with hypocalcaemic fits secondary to vitamin D deficiency reported to the British Paediatric Surveillance Unit since December 2012: **4**

Regular readers of Paediatric Pearls will, I am sure, be ensuring that ALL their pregnant and breastfeeding patients are getting at least 400 units (10mcg) of vitamin D a day and that ALL breastfed babies are getting Healthy Start vitamins or the equivalent from 6 months of age or from 1 month of age if their mum is known to be vitamin D deficient. I (and the families, who often now say that they have asked their GP or midwife about vitamin D (but still not been given any)) would be very grateful if you would disseminate this DoH advice as widely as possible.

Child sexual abuse is under reported.

☞ In 2008/09, 16,094 children spoke to ChildLine about sexual abuse as either their main problem or an additional problem, representing 10% of all calls answered.
☞ Between 2004/05 and 2008/09, the annual number of children counselled by ChildLine regarding sexual abuse rose from 8,637 to 12,268 (42% increase).

The NSPCC has recently published a guide for parents on child sexual abuse. See Protecting children from sexual abuse: a guide for parents and carers. It has tips on how to recognise what is happening and who to report concerns to.

PAEDIATRIC SLEEP MEDICINE SERIES: Delayed Sleep Phase (DSP) or "What to do with night owls"

(with thanks to Dr Sophia Datsopoulos supervised by Professor Paul Gringras)

- Sleep onset delayed by ≥ 2hrs, often to 2-3am
- Common circadian rhythm disorder affecting 7% of adolescents (and some younger children)
- Probably reflects exaggerated reaction to normal shift in sleep times which occurs in adolescence
- Quality and length of sleep normal if allowed to sleep in. Getting up for school is a problem. May be thought of as lazy or unmotivated.
- Management focuses on manipulating the body clock:
  - **SLEEP HYGIENE**: avoid caffeine, no electronic gadgets, TV etc. in bedroom before bedtime
  - **BRIGHT LIGHT THERAPY**: 20-30 mins bright light exposure in the morning (I can hear the groans already in my household...) and avoid bright light in the evenings
  - **CHRONOTHERAPY**: delay sleep time by 2-3hrs every night while maintaining 8 hrs total sleep until the young person gets to 1030pm bedtime and stop there. Reinforce with bright light therapy at a suitable time in the morning in order to "anchor" the morning wake up time. (A project for the Easter holidays?) Low dose **MELATONIN** may help to trigger body clock
  - Management flow chart here.
- Consider depression which is present in up to 50% of cases

Further reading here. This information sheet comes from a book on paediatric sleep aimed at busy primary care practitioners: Mindell JA & Owens JA (2010). A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems, 2nd ed. Philadelphia: Lippincott Williams & Wilkins.

Patient information available at http://www.nhs.uk/Livewell/Childrenssleep/Pages/whyteenssleeptoomuch.aspx

Next month's sleep topic: **Disorders of initiating or maintaining sleep (DIMS)**

Recent useful (I hope!) uploads to Paediatric Pearls

How to read a paediatric ECG by Dr Farzana Bashir. Some good basics and a nice reminder of where to measure each segment from and to.

Algorithm on management of 1st afebrile fit in the Emergency Department by Drs Chris Kelly and Harriet Clompus supervised by Dr Corina O'Neill.

Allergy plans put together by Dr Lee Noimark which you can print out for your patients to give to school or nursery as individualised action plans.

Personalised eczema treatment sheets devised by Dr Anshoo Sahota with drop-down menus of medications to print out for adult or paediatric patients.

Helping baby to breastfeed leaflet from infant feeding coordinator Jo Naylor.

Paediatric Cardiac Arrest algorithm based on current APLS guidelines but with shockable and non-shockable protocols on one diagram.