Paediatric Pearls

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

Headache:

History and examination is everything. In Abu-Arafeh's cohort (ADC 2005), 3 cases out of 815 children had active intracranial pathology and 2 were predictable from their histories. The 3rd was unexpected and presented later.

Important question: **What happens between headaches?**

Primary headache	Secondary headache
Complete recovery	Personality change, academic decline, loss of visual acuity, vomiting, faltering growth, neurological signs

Children's headache training from http://www.bpna.org.uk/headache/

In April the MHRA warned that **domperidone** is associated with a small increased risk of serious cardiac side effects. The dosage and duration of use have been reduced and it is now contraindicated in those with underlying cardiac conditions. Risk is higher in patients > 60 years, adults taking daily oral doses > 30mg, and those taking QT-prolonging medicines or CYP3A4 inhibitors concomitantly. "Patients currently receiving long-term treatment with domperidone should be reassessed at a routine appointment to advise on treatment continuation, dose change, or cessation."

MRHA suggested doses:

- For adults and adolescents > 12 years old and weighing ≥ 35kg, the recommended maximum dose in 24 hours is 30mg (dose interval: **10mg up to three times a day**)
- In children < 12 years of age and < 35kg, recommended max dose in 24 hours is 0.75mg/kg body weight (dose interval: **0.25mg/kg body weight up to 3 times a day**)

The Neonatal and Paediatric Pharmacists Group (see www.nppg.org.uk home page) have come up with a more balanced position statement on what we should do about prescribing domperidone in our young population whose risk of cardiac conditions is so much lower:

- In congenital heart disease – consider prescribing an alternative
- Others with nausea and vomiting or established GORD – consider reducing dose to 0.25mg/kg tds at next routine appointment.
- Newly diagnosed reflux – conservative measures first for at least 2 weeks. If domperidone is deemed necessary, consider ECG first to check Q-T interval then start at 0.25mg/kg tds. If symptoms refractory, can go up to 400mcg/kg (max 20mgs) tds but suggest regular cardiac monitoring.

Dermatology series :- **pityriasis rosea** (which I think I must have missed in the past, or treated – at least the herald patch - as ringworm) with thanks to Dr Andrew Lock, dermatology specialist registrar @ Royal London Hospital

- Benign, acute papulosquamous eruption usually lasting 6-8 weeks
- Unknown aetiology, possibly post viral.
- Affects children and young adults of any race, rare in infants, most common in 10-25 year old age group
- A small number have a mild prodrome of viral symptoms (ask about recent URTI), but patients are otherwise well.
- In >50% the first clinical sign is a "herald patch" (usually on the trunk); a salmon coloured plaque which enlarges, with a fine collarette of scale, just inside a well defined border.
- "Christmas tree"- describes the symmetrical pattern of the subsequent eruption of lesions along skin tension lines on the trunk.
- Lesions do not scar, but post inflammatory hyper and hypopigmentation can occur

Differential diagnosis: (not exhaustive) Viral exanthem, guttate psoriasis, nummular eczema, seborrhoeic dermatitis, tinea corporis, pityriasis versicolor

Management: Skin scrapings for mycology only if tinea suspected, reassurance (not considered transmissible, so can return to school), emollients and mild or moderate potency topical steroids if itching (rash is pruritic in 50%)

These links have great pictures and more detailed information:
http://www.dermnetnz.org/viral/pityriasis-rosea.html
http://www.pcds.org.uk/clinical-guidance/pityriasis-rosea

Patient information leaflet from British Association of Dermatologists

We are still getting **children with constipation** referred to paediatric outpatients in whom only a small dose of lactulose has been tried in primary care. Please note that the first line treatment has been Movicol (paediatric version if under 12, adult formulation once >12yrs) since the NICE guideline was published in 2010, and NICE have just re-emphasised that in their Quality Statement 62 published last week.

Functional constipation = 2 or more of the following criteria in previous 1-2 months:

- ≤ 2 defecations per week
- ≥ 1 episode of faecal incontinence per week
- Retentive posturing (straining hard *not* to poo)
- Painful or hard bowel movements
- Presence of a large faecal mass in rectum (PRs not advised in children)
- Stools obstructing toilet

Further information: NICE clinical pathway – good but requires a few clicks to read all the main points
Barnet CCG's 1 page guideline (including Movicol doses) and Bristol stool chart available from www.paediatricpearls.co.uk/primary-care-guidelines/
Auth M et al. Childhood Constipation. BMJ 2012;345:e7309
www.eric.org.uk for resources for parents and children on constipation and encopresis.

http://www.chainofprotection.org is a public education website put together by Professor Robert Booy who spoke very engagingly about immunisation (and all the viruses bats carry...) at a conference I attended last week. He is an Australian professor of paediatric infectious diseases and immunology with a passion for telling families **the truth about vaccines**. Plenty of videos on the site about various infectious diseases (not the bat ones though) and sensible patient information sheets on vaccine safety including MMR, thiomersal, Hep B etc.

Dr Tom Waterfield has been let off his "from the literature" post this month due to being on paternity leave! Congratulations to you both on the birth of young Alexander. Now begins the true paediatric education.....

Domestic violence (DV) and abuse: how health services, social care and the organisations they work with can respond effectively. February 2014. www.guidance.nice.org.uk/ph50

...is about identifying, preventing and reducing domestic violence and abuse and, while child abuse is not dealt with per se, the guideline does cover support for children who are affected by DV and abuse.

- In 2010/11 in England and Wales, 7.4% of women and 4.8% of men experienced DV and abuse, defined as: **physical abuse, threats, non-physical abuse, sexual assault or stalking** perpetrated by a partner, ex-partner or family member. At least 29.9% of women and 17.0% of men in England and Wales have, at some point, experienced DV.
- Each year since 1995, approximately half of all women (and 12% of men) aged 16 or older murdered in England and Wales were killed by their partner or ex-partner.
- There is a strong association between domestic violence and abuse and other forms of child maltreatment: it was a feature of family life in 63% of the serious case reviews carried out between 2009 and 2011. 24.8% of 18-24 year olds surveyed had experienced it during their childhood.
- All staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of domestic violence and abuse, how it affects people's lives and the role of professionals in intervening safely.
- Recommendation 6: Ensure trained staff ask people about DV and are able to point them towards suitable support groups
- Recommendation10: identify children and young people affected by DV and abuse and refer accordingly.

Click here for support groups and refuges in Waltham Forest including specific help for people in same sex relationships and those fleeing a forced marriage situation. Domestic violence one stop shop in Redbridge. http://www.raada.org/ for women and children in Redbridge affected by domestic abuse.