

Paediatric Pearls

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

When should a child with **obesity** be referred for further assessment?

With thanks to Dr Hajera Sheikh

The vast majority (>95%) can be dealt with in primary care.

Go For It is a free 10-week healthy lifestyle programme for children aged 4-12 and their families.

Teen Why Weight is a free 4-week weight management programme for teenagers.

Phone the N.E.L.F.T community dieticians on 020 8430 8096 to book a space or find out more.

Nationally, follow the link to MEND <http://www.mendcentral.org/>

However, consider referring to secondary care if:

- 1) Extreme obesity (BMI > 98th centile) ([link to BMI calculator](#)) or evidence child's health is affected by their obesity.
- 2) Possibility of secondary obesity:
 - ☞ Short stature for genetic potential/poor growth ([link to height potential calculator](#))
 - ☞ Dysmorphisms (see [full article](#) for more detail)
 - ☞ Learning difficulties
- 3) A likelihood of comorbidity, check for:
 - ☞ Hypertension
 - ☞ Symptoms of sleep apnoea
 - ☞ Acanthosis nigricans
 - ☞ Evidence of polycystic ovarian syndrome (PCOS)
- 4) Child safeguarding concerns
- 5) Biochemical evidence of impaired glucose tolerance, dyslipidaemia, liver dysfunction
- 6) Family history in close relatives: type 2 diabetes < 40 years, or cardiovascular disease < 60

For children, with psychological morbidities, refer to CAMHS. See [here](#) for investigations in secondary care and when to refer on to a subspecialist.

Reference: Assessment of childhood obesity in secondary care: OSCA consensus statement. Viner et al. *Arch Dis Child Educ Pract Ed* 2012;97:98-105

Families can join free at www.nhs.uk/Change4Life for lots of advice on healthy living



Adrenaline for bronchiolitis: Papers are often published looking at whether nebulised adrenaline reduces the need for hospital admission in babies with bronchiolitis but studies and meta-analyses over the years have not supported the practice. Dr Sangeetha Pradeep, paediatric registrar, revisited the topic recently. Her short paper and [summary of current evidence is here](#). In June 2013, a Norwegian paper was published in NEJM ([N Engl J Med 2013](#); 368:2286-2293) which also showed no difference in outcome in those given adrenaline compared to saline. Importantly, for me, the mean age of this study cohort was 4.2 months which I think is less likely to mean there were older viral induced wheezers caught up in the group. **What do others say on this topic?**

"Bronchodilators should not be routinely used; if a trial of an alpha-adrenergic or beta-adrenergic medication is an option, the agent should be continued only if a positive (and continued) response is documented" *American Academy of Pediatrics*

NICE are working on a guideline on the diagnosis and management of under 2s with bronchiolitis, aiming for publication in April 2015. For now, we have the [November 2006 SIGN guideline](#) which states categorically that adrenaline is not recommended for treatment of children with acute bronchiolitis. Neither are steroids, salbutamol or antibiotics by the way.

BCG Lymphadenitis

With thanks to Dr Mujahid Hassan



DIAGNOSIS is clinical:

- Isolated lymph node enlargement
- BCG vaccination to ipsilateral side
- Absence of tenderness or heat
- Absence of fever
- Most are *non-suppurative* (see photo) and resolve spontaneously within a few weeks
- *Suppurative* ones are swollen, red and fluctuant and may benefit from fine needle aspiration.

Full article on this subject at <http://www.paediatricpearls.co.uk/2013/11/bcg-lymphadenitis/>

Management of UTI in children ([Click here](#) for a clear, concise guideline on treatment, imaging and follow up, based on NICE guideline):

High risk of serious illness and/or children younger than 3 mths	Refer paediatrics.
Acute pyelonephritis/ upper UTI i.e. bacteriuria and fever of 38°C or higher or bacteriuria, loin pain/tenderness and fever < 38°C	Consider referral to paediatrics. Treat with 7-10 days oral cefalexin. If oral antibiotics cannot be used, refer for IV cefuroxime for 2-4 days followed by oral antibiotics for total duration of 10 days.
Cystitis/lower UTI	Probably no need to admit. Treat with oral cefalexin for 3 days

"From the literature" series by Dr Tom Waterfield: **Do antipyretics prevent febrile convulsions?**

Febrile convulsions are common in the UK affecting 2-4% of children. They typically occur in children aged between 6 months and 6 years and there may be a family history. The condition is typically benign with most children growing out of it; there is no link between simple febrile convulsions and epilepsy.

Despite this, febrile convulsions remain a source of significant parental anxiety and I was reminded of this earlier in the week when a parent explained how they had been giving their child regular Paracetamol during a recent viral illness to prevent a febrile convulsion. So how effective is this strategy for preventing febrile convulsions?

A Cochrane review published in April 2012 combined data from 36 studies (26 randomised) including 2740 children over 45 years and found no benefit of antipyretics (Paracetamol/Ibuprofen) (1). A further meta-analysis of three studies (540 patients) published earlier this year in the European Journal of Paediatric Neurology again found no statistically significant effect of antipyretic prophylaxis on the recurrence rates of febrile convulsions (2).

Prophylactic antipyretic medications have no role in the management of febrile convulsions and parents should be reassured with regards to the benign nature of the illness and given basic first aid advice. **As doctors we should not recommend prophylactic antipyretic medication for the prevention of febrile convulsions.**

- 1) Offringa M, Newton R. Prophylactic drug management for febrile seizures in children. *Cochrane Database Syst Rev*. 2012 Apr 18;4:CD003031.
- 2) Rosenbloom E, Finkelstein Y, Adams-Webber T, Kozar E. Do antipyretics prevent the recurrence of febrile seizures in children? A systematic review of randomized controlled trials and meta-analysis. *Eur J Paediatr Neurol*. 2013 May 21. pii: S1090-3798(13)00065-2.

[Patient.co.uk](#) has a good information leaflet for parents on febrile convulsions with first aid tips and a clear explanation of the difference between simple and complex febrile seizures if any clinicians need a reminder. The message about antipyretics from Tom, patient.co.uk and NICE in their [fever guideline](#) is the same – **treat the child, not the temperature**. A child with a high fever but no pain or distress should not be given antipyretics.