Paediatric Pearls

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

Welcome to the new paediatric trainees!

It is a time of year when everyone's learning curve is pretty steep: ST4s learning to make decisions, ST1s wondering what they've let themselves in for and consultants trying to learn the computer systems they've been relying on the old trainees' IT skills for.... Paediatric Pearls is primarily aimed at non-paediatricians who are working with children but houses some pretty useful information, patient/parent leaflets and links for all of us so do use the website. I have listed a few topics I use quite regularly in the September 2013 newsletter. Other particularly useful material added this year includes:

Review of obesity investigations and management, faddy eating in toddlers resources, dermatology series from January 2014 to current, headache top tips from March to August 2014, advice on taking blood from children and a reminder of heart and respiratory rates to be concerned about at different ages.

Learn Pediatrics videos, from the University of British Columbia, Canada, provide comprehensive tutorials on examination of the child's different systems which make useful viewing for those just starting out in paediatrics. You will need to shorten the "basic" examinations featured here though if you are going to see more than one patient per day! Watch in particular the interaction between the doctor and child and how she puts the child at ease.

We are all here to help you. Ask for advice when you need it and listen to the senior nurses – they have a wealth of experience in dealing with ill children and their families. Paediatrics is very much a multidisciplinary field and we rely heavily on our non-medical colleagues to guide, help and occasionally challenge our practice. **Enjoy yourselves and learn lots!**

CPD courses for GPs:

Guys and St Thomas' have places on their 4 day GP update course in November. Adult and child topics.

www.allergyacademy.org always have useful courses on their menu. Asthma and food allergy days in November.

As does the Academy of Paediatric Gastroenterology which is sharing the food allergy day on 27/11/14 and running a general paediatric gastro update on 3/11/14.

Part 2 of NICE's "do not do" recommendations (see August 2014 for explanation):

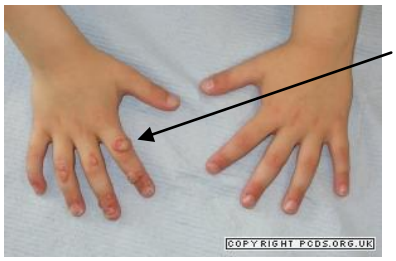
From Depression in children and young people (CG28) publ. Sept 2005:

- Antidepressant medication should not be used for the initial treatment of children and young people with mild depression
- Antidepressant medication should not be offered to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy

From Feverish illness in children (CG160) publ. May 2013:

- Do not prescribe oral antibiotics to children with fever without apparent source
- Antipyretic agents do not prevent febrile convulsions and should not be used specifically for this purpose
- Tepid sponging is not recommended for the treatment of fever
- Do not routinely perform blood tests and chest X-rays in children with fever who have no features of serious illness (that is, the 'green' group in the traffic light chart)
- When using paracetamol or ibuprofen in children with fever, do not give both agents simultaneously
- Do not use antipyretic agents with the sole aim of reducing body temperature in children with fever

Dr Andrew Lock continues his dermatology series with a look at warts:



- Benign growths of the skin due to Human Papilloma Virus
- Very common: most will have warts in childhood
- Not highly contagious. Usually transmitted onto broken skin
- Close up features incl. black dots (thrombosed capillaries)

Main Treatments (none has a high success rate)

- No treatment (up to 90% of warts will resolve within 2 years without scarring)
- Salicyclic acid preparations (not advised for facial warts)
- Cryotherapy (painful, may cause dyspigmentation). Best to use cotton applicator stick for facial warts
- Duct tape (mainly anecdotal evidence. See either leaflet below for more info.)

Treatment tip: Paring of warts 1-2 times per week with an emery board may reduce pain and will improve efficacy of treatments. Instructions at: http://www.pcds.org.uk/ee/images/uploads/general/Warts_-_Soak_Pare_and_paint.pdf

Anogenital warts: Not all anogenital warts are sexually transmitted. However, in children a consideration has to be given to the possibility of sexual abuse. The possibility of **non-sexual** transmission is more likely if:

- There are no other suspicious features
- The warts are located on fully keratinised skin as opposed to the genital or anal mucosa
- There is a clinical resemblance to common warts
- The child is very young, perhaps up to two years old - in such cases the warts may have been transmitted at birth from the mothers genital tract

General guidance and clinical information on all types of warts from PCDS:
http://www.pcds.org.uk/clinical-guidance/warts

Printable patient.co.uk leaflet on warts and verrucas:
http://www.patient.co.uk/print/4359

Can my child still swim? YES (see patient.co.uk link above)

Dr Tom Waterfield is updating Luton's guidance on the management of Bell's palsy and has pointed out that there was new guidance in 2012 from the American Academy of Neurology, the main change being an increased emphasis on the use of steroids early in the presentation[2]. The evidence for this is graded 1B which means it is a strong recommendation but there are limitations and in this case it is that 2 recent RCTs[3, 4] have shown an improvement in long term outcome in *adults* but children have not been studied. The vast majority of children get better anyway within 2 or 3 weeks. Should we be changing our practice and opting for early steroids in them too? Click here for Tom's full article and list of references so you can make up your own minds in individual cases!

Bell's palsy is an idiopathic facial nerve palsy first described by Sir Charles Bell in 1830. It typically presents with a sudden onset of unilateral facial palsy. It presents as a unilateral *lower* motor neurone weakness ie. the forehead is also involved (if the forehead is not involved, this is an *upper* motor neurone weakness with a different aetiology and needs prompt referral for further investigation). The prognosis in true idiopathic Bell's is typically good with up to 90% of children recovering by 3 months[1]. The mainstay of management in children is supportive (artificial tears/patching). Prednisolone works by reducing inflammation of the facial nerve but its use in children is not widespread yet despite UpToDate coming off the fence in their recent article to state that "for children with idiopathic acquired facial palsy (ie, Bell's palsy), we recommend early treatment with oral glucocorticoids (Grade 1B). Treatment should preferably begin within three days of symptom onset. Our suggested regimen is prednisone 2 mg/kg daily (up to 60 to 80 mg) for five days, followed by a five-day taper."

What do others say?

Most internet sources, including the support groups, are not as positive about the need for steroids as UpToDate is. Or maybe they are just behind. We urgently need an RCT looking just at paediatric patients. Until then, patients and their parents should be involved in the decision to treat or not.

http://www.rch.org.au/kidsinfo/fact_sheets/Bells_palsy/ from Melbourne, Australia, was updated in 2012 and does not overtly support the use of steroids in children. There's a good American information leaflet aimed at children at http://kidshealth.org/kid/health_problems/brain/bells_palsy.html#. There are also teenage and parent and Spanish versions of this leaflet on this site.