Paediatric Pearls

by Dr Julia Thomson, Paediatrician

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Monthly paediatric update newsletter for all health professionals working with children – put together by Dr Julia Thomson, Paediatric Consultant at Homerton University Hospital, London, UK. Housed at www.paediatricpearls.co.uk where comments and requests are welcome!

CYP in care do not always appreciate the terminology around their condition that professionals use (see April/May newsletter). Here are some more of their suggestions, taken from a document by TACT (The Adolescent and Children's Trust), the UK's largest fostering and adoption charity and voluntary agency https://www.tactcare.org.uk/content/uploads/2019/03/TACT-Language-that-cares-2019_online.pdf:

LAC/Foster child

We prefer: **Call children by their names; LA should say 'our children' or [insert name of LA]'s children; Young People or Children**

> *"Every child is 'looked after'; there is no need to point us out. Some would consider themselves looked after before coming into care."* Cheshire East Young People

> *"I do not mind the saying, but just don't say it a lot."* York Young Person

> *"The acronym 'LAC' can be understood as a suggestion that the child or young person is 'lacking' something."* Professional

> *"Take away LAC acronym completely."* Herefordshire Young People

Leaving care

We prefer: **Moving on or Moving up**

Social worker

We prefer: **One to one worker; Someone who understands your family background and knows what you have been through**

Special needs

We prefer: **Additionally supported; The needs name, i.e. disabled, global developmental delay, learning need, etc.**

> *"Everyone is special, and everyone has different levels of need."* Warwickshire Young People

The 2019 intercollegiate safeguarding documents about our roles and competencies as healthcare staff are available via the links below:

Adult safeguarding: https://www.rcn.org.uk/professional-development/publications/pub-007069

Child and Young People safeguarding: https://www.rcn.org.uk/professional-development/publications/007-366

A quick reminder re child safeguarding CPD requirements:

Refresher training

- Over a three-year period, professionals should be able to demonstrate refresher education, training and learning[cv] equivalent to:
  - a minimum of eight hours for those requiring Level 3 core knowledge, skills and competencies[cvi]
  - a minimum of 12-16 hours[cvii] for those requiring role specific additional knowledge, skills and competencies.

All of us who work face-to-face with children as part of our everyday work (GPs, ED practitioners, paediatricians, practice and paediatric nurses, midwives, paramedics etc.) fall into the min 12-16 hour CPD "role specific" group.

Read the TACT document above on the use of care language, reflect on it, and that could well be your 1 hour's child safeguarding CPD for this month.

What does "the urine dipstick is positive for blood" actually mean?

	Dipstick	Microscopy	Think!
Haematuria	Blood ++	RBCs ++	Infection, oncology, trauma, kidney
Haemoglobinuria	Blood ++	RBCs – or a few	Haemolytic anaemia
Myoglobinuria	Blood ++	RBCs – or a few	Rhabdomyolysis
Pseudohaematuria	Blood -/+	RBCs -	Beetroot, rifampicin, porphyria

The reagent on the test strip lyses any RBCs and detects the presence of pigment such as haemoglobin or myoglobin, not just blood. If there is free haemoglobin anyway in the urine because of acute intravascular haemolysis, the dipstick will show up as positive for "blood".

"Hemoglobinuria misidentified as Hematuria" at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4222305/

Approach to macrocephaly in a child

Raised fluid pressure:
- Hydrocephalus
- Choroid plexus papilloma
- Subdural collections
- Brain tumour
- Expanding subarachnoid cyst

☞ Refer to secondary care for MRI or CT

Benign familial macrocephaly - most common cause, no action needed.

Metabolic:
- Leukodystrophies
- Alexander
- Canavan
- Organic aciduria

☞ Refer to secondary care

Genetic:
- Neurofibromatosis I
- Tuberous sclerosis
- Soto's Syndrome
- Weaver syndrome
- Fragile X syndrome
- Neuro-cardio-facial-cutaneous syndromes eg. Noonan's, Costello, LEOPARD

☞ Refer to secondary care if undiagnosed

Associated with ASD

☞ Refer to Child Development Clinic if other autistic features

Skull deformities, frontal bossing (BESS?), hyperostosis, thalassaemias.

☞ Plot H/C, cranial USS, Vitamin D level and PTH, screen for haemoglobinopathies

Apparently large head eg. infant with IUGR.

☞ Plot H/C regularly and refer if crossing 2 centiles or if there is developmental delay.

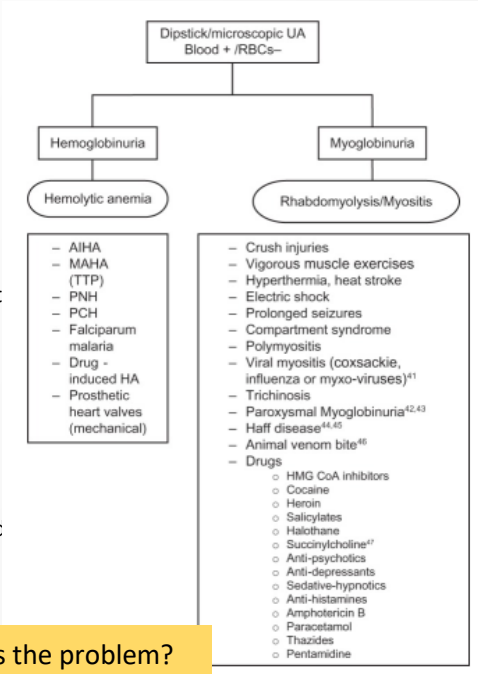
Reference: useful "15 minute" summary of the clinical approach to an infant with a large head, see https://ep.bmj.com/content/98/4/122.

LESSONS FROM THE FRONT LINE – Coca Cola Urine

An 8-year-old girl was brought to the ED one evening by her mother because of excessive tiredness. Mum mentioned that she had had dark brown urine for the past 4 days. She had recently been admitted and treated for malaria. She was of West African origin and had been found to be G6PD deficient on routine testing done as part of her recent malaria work-up.

Her urine dip was positive for blood, initial Hb was 70g/L, dropping to 50 a couple of hours later when a line was reinserted. This prompted plans for a transfusion and by the time the blood was ready, her Hb had dropped to 20.

The technician running a CMV test an hour or so later thought the blood looked watery and checked an Hb to be helpful. The result was 10g/L but by that time the transfusion was running. She felt (and looked) significantly better by the morning. She only required that one transfusion.



What was the problem?

Dr Neaha Patel, paediatric registrar at Homerton, looks at the differential of coca-cola coloured urine for Paediatric Pearls over the next few months.