What to do when you can’t find an orchidometer by Dr Mojgan Ezzati, paediatric consultant at Homerton, who recently presented a very helpful, practical synopsis of precocious puberty.

Tanner stage 1: pre-puberty tests < 2.5cm long or < 4mls testicular volume (tv) Tanner stage 2-3: in puberty ab normal if < 9 years of age in boys – REFER NB: 40-65% of males in this stage have temporary breast tissue growth = NORMAL Tanner stage 4-5: completing puberty boy’s peak growth velocity is at tv 9-10mls

Click here for a useful Aide Memoire to pubertal staging and indications for referral to secondary care in both boys and girls.


I was not the only paediatric consultant in a recent departmental teaching session not to know that, when plotting children on growth charts, we should correct differently for prematurity in babies < 32 weeks gestation and the cohort born between 32 and 36+6 weeks. Dr Katie Ruck, paediatric registrar, contacted the RCPCH for clarification and then put together this helpful aide memoire which is also on the Primary Care Resources page of the website:

**Growth Charts:** an important indicator of child health, but are we getting it right?

**Correction for Prematurity**

<table>
<thead>
<tr>
<th>&lt;53 weeks</th>
<th>32 - 36 weeks</th>
<th>37 weeks and up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct up to 1 year</td>
<td>Correct up to 1 year</td>
<td>Correct up to 1 year</td>
</tr>
</tbody>
</table>

**Recognition of Faulting Growth**

<table>
<thead>
<tr>
<th>Birth weight</th>
<th>Adjusted weight</th>
<th>&lt;5th centile</th>
<th>&lt;5th centile</th>
<th>&lt;5th centile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weight</td>
<td>Full across 3/5 centile spaces</td>
<td>Full across 3/5 centile spaces</td>
<td>Full across 3/5 centile spaces</td>
</tr>
</tbody>
</table>

**More on**

- BMJ. 368, l6597. 10.1136/bmj.l6597.
- https://www.pennacare.org/client-library/resuscitation-guidelines/3923796.0.html

E.g. plasmalyte A

Photographs and images in virtual consultations: It is tempting to violate the context of face-to-face appointments being limited to rely on digital images, recordings and screenshots to aid diagnosis. While it can be extremely helpful to take photos, for example of rashes, burns or birthmarks, and videos of unusual movements or suspected seizures, there has been evolving discussion and guidance about the ethics of receiving and storing images of this type in children and young people.

**Limitation of images** – images do not always reflect what would be seen on physical examination. If you are assessing something using an image there will be limitations on what you can appreciate. With this in mind do you need a face-to-face appointment or clinical photography to be arranged?

- Bruising or other skin changes of significance in safeguarding should have clinical or forensic photography and face to face assessment (https://childprotection.rcpch.ac.uk/resources/service-delivery-standards/)
- Parents or young people should not routinely be asked to take photographs which would be considered intimate images (genitals, anus, perineum, breasts).
- CYP and their parents should not feel pressure to take or share images online. They should know that by not providing an image their clinical care will not be affected.

More information can be found here: RCPCH guidance for professionals on having good online appointments.

**IMPORTANT DOWNLOADS:**
- Paediatric ALS Algorithm 2021
- Paediatric Cardiac Arrhythmias Algorithm 2021
- Paediatric Emergency Drug Chart
- Newborn Life Support Algorithm 2021

- perform assessment for signs of life (circulation) simultaneously with breathing assessment
- Use speaker function on mobile phone to call emergency services and receive instructions
- More on end tidal CO2 monitoring at https://www.rcpch.ac.uk/library/2021-resuscitation-guidelines/cardiovascular-monitoring
- Keep the patient flat, maintain an open airway by either continued head tilt and chin lift or jaw thrust. Once breathing but still unconscious, try the recovery position if there is a risk of vomiting.
- 2-person bag-mask ventilation (BMV) is best, followed by early supraglottic airway oruffed or intubated tracheal tube. Note BPM by age once child intubated with uninterrupted chest compressions.
- Titrated O2 to SpO2 of 94-98% in seriously unwell or injured children and post cardiac arrest with return of spontaneous circulation (ROSC).
- Don’t waste time verifying the absence of a pulse; if no signs of life, start chest compressions immediately after 5 rescue breaths.
- Chest compression depth at least one third the anterior-posterior diameter of the chest, or by 4 cm for the infant and 5 cm for the child.
- Minimise pauses so that chest compressions make up at least 80% of CPR cycle.
- Adrenaline within 3 minutes of identification of non-shockable cardiac arrest. Early IO access.
- Lidocaine 1mg kg-1 can be used in shockable side of algorithm instead of amiodarone by “providers competent in its use”.
- Note fluid bolus volume and type changes
- Note inotropic type, route and timing changes
- Note changes to SVT algorithm in linked download above. Modified adenosine doses, early shock recommended if decompensated with IM or intranasal ketamine for sedation.