Paediatric Pearls

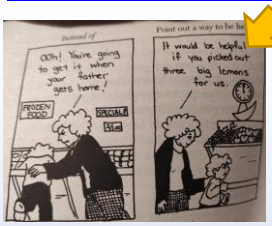
by Dr Julia Thomson, Paediatrician

April 2022

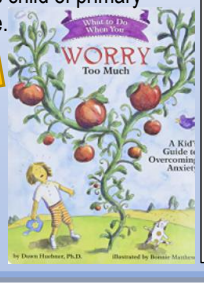
Monthly paediatric update newsletter for all health professionals working with children – put together by Dr Julia Thomson, Paediatric Consultant at Homerton University Hospital, London, UK. Housed at www.paediatricpearls.co.uk where comments and requests are welcome!

Miscellaneous resources to support our patients' parents:

How to Talk so Kids will Listen and Listen so Kids will Talk. Adele Faber and Elaine Mazlish, Piccadilly Press 2013, is good. It is full of practical, respectful suggestions of alternative ways to speak with children of all ages. There are other titles in the series for specific age groups.



What to do when you worry too much is an excellent CBT based workbook for a parent to do with an anxious child of primary school age.



Father2father is recruiting parents (until 19th May) for their 10 week parenting course entitled "Tools for the Teenage Years" which is due to start in May 2022. **The course is free and open to families in Hackney with children between the ages of 9 and 25, from African, Caribbean and mixed heritage.**

NOW TAKING BOOKINGS!

Tools for the Teenage Years Parenting Programme in City and Hackney

Father2Father

Starting: 5th May 2022
Thursdays 1pm to 3pm or 7pm to 9pm
How: Online using Zoom
Register: www.father2father.co.uk 07930 699 970

Care for the Family has a sensible teenage parenting course for those of all faiths or none and groups can facilitate their own with the resources provided.

Off the Record is based in Bath and has some good, easily accessible resources for teens and their parents on issues such as eating, exams, mood disorders and sleep.

Please email me your own go to parenting resources!

https://www.youngminds.org.uk/ is a charity which provides young people with tools to look after their own mental health. It offers parents a webchat function and support line and runs training courses for professionals.

Did you know? Children with chicken pox and shingles should be kept off school for 5 days from the start of the rash and until all the spots have crusted over. Islington has produced a helpful guide entitled "Minor illness and school attendance" aimed at improving attendance.

FROM THE FRONT LINE – non-blanching red spots in a systemically well child

A well-looking 5-year-old child is brought to see you because of red, pin prick type marks on his legs and back that don't go away when mother presses them. He has just recovered from a snuffly nose and sore throat. You are not particularly concerned about sepsis, leukaemia or NAI and think the child is likely to turn out to have one of those two acronyms, HSP or ITP. But which is it?

Purpura – purple discoloration 2° to haemorrhage from small blood vessels
Petechiae - <2mm purpura and usually signifies thrombocytopaenic bleeding
Ecchymoses – any purpura >2mm including "bruises" in lay terminology

Recent HSP resource: https://www.piernetwork.org/hsp.html
ITP resource: Provan D, Arnold DM, Bussel JB et al. Updated international consensus report on the investigation and management of primary immune thrombocytopenia. Blood Adv. 2019 Nov 26;3(22):3780-3817

	Immune thrombocytopaenic purpura (ITP) with thanks to Dr Jack Scannell, paediatric registrar	Henoch-Schoenlein purpura (HSP) with thanks to Dr Dharini Chandrasegaran, paediatric SHO, supervised by Dr Cauvery Pal, paediatric consultant
What is it?	Autoimmune bleeding disorder characterised by abnormally low levels of platelets	Commonest vasculitis of childhood, multisystem inflammatory disorder of unknown aetiology
Incidence	2.5 per 100,000 per year	13.5-21.7 per 100,000 per year. More common in winter.
Mean Age	5.7 years (slight female preponderance)	90% of cases occur between 2 and 10 years of age, peak incidence 4-7 years (boys > girls)
History	Well in self, acute history of bruising (87%), petechiae (74%) or mucosal bleeding (up to 25%) in last 24-48hrs. Might be a history of immunisation (7%) or viral infection (47%)	Well in self, recent history of viral URTI or streptococcal infection. 75% of patients present with a palpable purpuric rash, classically over lower limbs and buttocks
Complications	Rarely, intracranial bleeds (0.1-0.4%)	Intussusception, pancreatitis, nephrotic and nephritic syndrome, orchitis, parotitis. Rarely: stroke, Guillain-Barre, pulmonary haemorrhage
Red flags	Age < 6 months FH of bleeding disorders Insidious onset Bone pain Looks unwell at presentation	The diagnosis is usually fairly clear but red flags for more severe complications include: Severe joint and/or abdominal pain Melaena Oedema and hypertension
Parent information	https://www.evelinalondon.nhs.uk/resources/patient-information/ITP-in-children.pdf Avoid NSAIDs, im injections, piercings, contact sports. Stay active, first aid advice for nose bleeds, cycle helmet and return if drowsy or has headache or new significant bruising / bleeding	See appendix at https://www.piernetwork.org/hsp.html or https://www.gosh.nhs.uk/conditions-and-treatments/conditions-we-treat/henoch-sch-nlein-purpura-hsp/
Initial investigations	FBC, clotting and film	Initial BP & urine dipstick U&E, FBC, Coagulation
Clinching the diagnosis	Well child with no concerning features in the history Low platelets but other cell lines unaffected Blood film confirms true thrombocytopaenia with no blasts	Palpable purpura with at least one of the following: 1. Diffuse abdominal pain (in 50% of children and may precede the rash) 2. Arthritis (acute) or arthralgia (seen in up to 84% of children) 3. Renal involvement (any haematuria and / or proteinuria (seen in 40-60% but may present many weeks later) 4. Any biopsy showing predominant IgA deposition
Management	Treat clinically rather than on platelet count There has been an increasing trend towards conservative management over the last 20 years in the UK If treatment is required, IVIG is first line +/- steroids Tranexamic acid may help mucosal bleeding but does not affect underlying disease process. Platelet transfusion is rarely helpful.	Usually supportive, NSAIDs can be used for arthralgia if no active bleeding Consider prednisolone for gut involvement Discuss with tertiary centre if renal involvement
Follow up	Follow till platelets >50 and no active bleeding	See appendix at https://www.piernetwork.org/hsp.html for explanatory template letter to GP and flow chart for follow up. BP and urine dipstick done in primary care or by community paediatric nurses initially weekly, then monthly for 6 months unless there is macroscopic haematuria, proteinuria or hypertension when the child should be referred back to secondary care. Follow up for 6 months at least and then until there is no microscopic haematuria.
Prognosis	80% have recovered completely by 6 months, very low recurrence rate. 10-15% have persistent ITP for up to a year. 10% have chronic ITP which persists for more than 1 year.	Exacerbations may occur with OCP, periods and pregnancy. 16-40% have at least one recurrence which can be up to 2 years later.