Paediatric Pearls

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

What is PEWS?

The Paediatric Early Warning Score (PEWS) was initially devised as a method of predicting which children would need HDU or PICU care. It has recently been validated in this context and the full text paper is at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2750193/pdf/cc7998.pdf . It has also been assessed as a triage tool in paediatric A and E (Bradman K, Maconochie I. *Eur J Emerg Med* 2008;**15**(6):359-60) but the authors concluded that PEWS was of limited value in predicting admission in a population with undifferentiated disease. A **low PEWS had a strong negative predictive value for the child's needing admission** but a **high PEWS did not necessarily predict the need for admission**.

In the Whipps Cross ED, we use the PEWS more as a *marker* than a predictor. A marker of how sick a child is at a given time (usually triage) and therefore of how fast the child should be seen, by whom and where. The PEWS scale at Whipps allows children to be graded as white, yellow, amber or red dependent upon their respiratory and heart rates and level of consciousness. There are **different PEWS for different age groups** and they are all displayed prominently in EUCC, paediatric A and E and in Majors' triage area. Please use them, especially if you are not formally trained in paediatrics (applies to both medical and nursing staff); shocked children can hide their predicament well until they start to decompensate badly but **their heart rate** will give the game away. The default place of assessment for any child who is "Red" on the PEWS chart (and they only need one of the parameters in the red column to qualify) is Resus.

We do audit the documenting of PEWS – you have been warned!

This month's featured NICE guideline:

Diagnosis and Assessment of Food Allergy in Children and Young People in Primary Care and Community Settings (Publ. February 2011)

Food allergy is an adverse immune response to a food. It is common and we all need to understand it a bit better – if only to keep up with the patients and their parents who are reading all sorts of good and not-so-good information about it on the Internet.

This guideline describes the **diagnosis of food allergy in the under 19 year old age** group. The Quick Reference Guide, available at http://www.nice.org.uk/nicemedia/live/13348/53217/53217.pdf is only 6 pages long! Print out pages 3 – 5 for a **graphic, all-encompassing algorithm on how to diagnose IgE and non-IgE mediated** food (including cows' milk protein (CMPA)) allergy.

The main take home points are:
☑ Take an allergy focussed history before doing any tests
☑ Pay attention to persistent symptoms involving >1 organ system
☑ Refer to secondary care if there is faltering growth with 1 or more GI symptoms, one or more acute systemic reactions (eg. confirmed IgE mediated allergy and asthma) or possible multiple food allergies
☑ Investigate suspected non-IgE mediated allergy with an elimination diet (and referral to a paediatric dietician if eg. CMPA in an infant)
☑ Investigate possible IgE mediated allergy with skin prick or specific IgE antibody tests

There is a bit more on food allergy in the GP version of March's Paediatric Pearls available on www.paediatricpearls.co.uk.

From the literature: Nasal Foreign Body: Kissing it better

A retrospective study of children attending with a nasal foreign body over a 15-month period. Of the 116 children with confirmed nasal foreign body, 84 were treated by the kissing technique with a success rate of 48.8%. There were lower rates of instrumentation and general anaesthesia. The average time saved per patient who had the kissing technique attempted in the paediatric emergency department was 30.6 min.
Emerg Med J. 2010 Sep;27(9):712-3. http://www.ncbi.nlm.nih.gov/pubmed/20581404

What is the kissing technique? Unfortunately Youtube does not have a video on this but the method, also called positive air pressure, where the parent blows into the child's mouth with the non-affected nostril occluded is described at http://emedicine.medscape.com/article/149299-treatment and I believe featured in an episode of ER once though the doctor used an ambu bag and mask to do the blowing.

Babies under 3 months

All children are streamed in EUCC by GPs or senior nurses. Of those that are streamed to paediatric A and E, some will be sent back to EUCC, once triaged by a paediatric nurse and deemed to be well enough to see a GP. ***Any babies under 3 months who do not go back to the GPs after triage will see paediatricians.***

Can I also remind you all ***that any child under 18 months with a fracture needs to be seen from a safeguarding point of view by paediatrics*** *before discharge from the ED?*

Feeling like you need updating on allergy?

www.allergyacademy.org has some great looking courses coming up for GPs, health visitors, nurses, pharmacists and ED physicians. Register on line now! There's a good review of anaphylaxis, after care and when to give an auto-injector (eg. Epipen) at http://ep.bmj.com/content/94/4/97.full but you will need your Athens password to see the full text of the article if you are not on a hospital computer. Current resus council anaphylaxis guidelines are at http://www.resus.org.uk/pages/reaction.pdf. A paediatrician needs to see children with anaphylaxis before discharge from the ED.