Paediatric Pearls

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

BTS/SIGN 2014: See previous months for Redources for parents and schools, recognition of asthma, assessment and categorisation of likelihood of asthma.

The aim of asthma management

is control of the disease. Complete control of asthma is defined as:

- ☺ no daytime symptoms
- ☺ no night-time awakening due to asthma
- ☺ no need for rescue medication
- ☺ no asthma attacks
- ☺ no limitations on activity including exercise
- ☺ normal lung function (in practical terms FEV1 and/or PEF>80% predicted or best)
- ☺ minimal side effects from medication.

Treat asthma using a "stepwise" approach, aiming for the least amount of therapy possible to achieve complete control as above. Before going up a step, check adherence to current therapy and inhaler techniques and try to eliminate trigger factors - only smoking and obesity have a proven link.

BTS/SIGN stepwise management diagrams:

1) 5-12 year olds (Steps 1-5) 2) Under 5s (Steps 1-4)

STEP 1: Mild intermittent asthma

- Prescribe an inhaled short-acting β2 agonist as short term reliever therapy for all patients with symptomatic asthma.
- Use PRN but be aware that good asthma control is associated with little or no need for short-acting β2 agonist.
- Anyone prescribed > 1 short acting bronchodilator inhaler device a month should be identified and have their asthma assessed urgently and measures taken to improve asthma control if this is poor.

STEP 2: Introduction of regular preventer therapy

Beclometasone diproprionate (BDP), eg Clenil modulite, and *budesonide*, eg turbohaler preparations, have 1:1 equivalence. Full BTS guideline lists the "BDP equivalence" of other steroid inhalers which may have the same effect (and side effects) at half the dose.

- Inhaled corticosteroids are the recommended preventer drug for adults and children for achieving overall treatment goals. Safe and effective in the under 5s but probably not necessary in non-atopic pre-school children.
- Consider if: using inhaled β2 agonists x3 per week or more; symptomatic x3 per week; waking one night a week; requiring oral corticosteroids in the last 2 years.
- Start children at 100mcg BDP twice a day. Titrate against symptoms to lowest effective dose. ≥ 400mcg total daily dose may be associated with systemic side effects in children. ≥ 800mcg per day BDP should be under a respiratory paediatrician.

What is a "floppy larynx"? Mr Sunil Sharma explains…

- Laryngomalacia ('immature' laryngeal cartilage) is the most common congenital laryngeal anomaly and the most common cause of stridor in neonates and infants (accounts for 60-70% of cases); it classically involves intermittent inspiratory stridor that improves in the prone position
- Laryngomalacia generally is self-limiting and usually resolves by the age of 18 months, but surgical intervention is warranted in those babies with failure to thrive or blue episodes; it can sometimes be associated with other airway pathology such as subglottic stenosis and tracheomalacia
- Feeding difficulties occur in about half of the babies. It is associated with gastroesophageal reflux which may require treatment. ENT surgeons assess the awake child using flexible fibre optic laryngoscopy. Only the severest 5-20% may need surgical intervention.

Thorne MC, Garetz SL. Laryngomalacia: Review and Summary of Current Clinical Practice in 2015. *Paediatr Respir Rev.* 2016 Jan;**17**:3-8. Full text of this excellent systematic review on the management of laryngomalacia available here.

Sensible information for parents on KidsGrowth site.

STRIDOR:

- 'Noisy breathing' in childhood is commonly reported by parents
- Stridor can be inspiratory (supraglottic or glottis pathology), biphasic (glottis or subglottic) or expiratory (distal tracheal or bronchial)
- Important questions to ask in the history include the onset of stridor, whether it is positional or intermittent, perinatal details, history of intubation, quality of cry and voice, drooling, failure to thrive
- The presence of cutaneous haemangiomas and stridor in a child should raise suspicion for subglottic haemangioma; up to 50% of patients with subglottic haemangioma have cutaneous involvement
- Croup is the most common cause of stridor in children, and management is medical with steroids, or nebulised adrenaline in severe cases
- Stertor refers to pharyngeal obstruction, and is a snoring noise, usually caused by enlarged adenoids and/or tonsils

An excellent systematic review on stridor: Pfleger A, Eber E. Assessment and causes of stridor. *Paediatr Respir Rev.* 2015 Oct 23. pii: S1526-0542(15)00114-1

Parent Infant Centre
It can be too late, but never too early.™

"He doesn't smile, doctor. He is 4 months old and he sometimes giggles to himself but he doesn't smile at me and he only looks at me after I've looked away." So said a mother in my clinic the very same week that I had been to visit the (private) Parent Infant Clinic in north London to find out what the child psychotherapists are doing there to pick up and then act on the early warning signs of a possible autistic spectrum disorder (ASD). ASD is not straightforward to diagnose; many very young children show some behaviours consistent with a social and communication disorder and grow out of them. Others who seem to be developing normally may regress later. Early labelling is not usually helpful but, in some cases, early input may enhance parenting skills and constructively support the family through a stressful period. The Acquarone Detection Scales for Early Relationships (used by the Parent Infant Clinic) is one example of an observational scale that provides a tool for assessing an infant's capacity to form relationships and a mother's ability to respond to her infant. Click here for more information and for a filled-in example scale.

In Barking and Dagenham, Havering, Redbridge and Waltham Forest we have the NHS perinatal parent infant mental health service (PPIMHS). Click here for their webpage and link to their referral form. They are happy to assess a baby and family as described above to help understand and make connections to the baby or if it was felt to be a bonding or mental health issue. They can also refer on to child development services if necessary. Other regional CAMHS may offer a similar service.

6TH FEBRUARY 2016 WAS "SAFER INTERNET DAY"

Whipps' safeguarding team reminded me that I had missed out a couple of good sites from last month's newsletter topic on E-safety:

http://www.childnet.com/ for lots of resources for parents, professionals and young people on keeping safe on line

http://www.thinkuknow.com/ is CEOP's site for young people and their parents. Formerly the "Child exploitation and on-line protection centre", officers now work alongside professionals from the wider child protection community and industry. Abuse and cyberbullying can be reported on this site.