

Paediatric Pearls

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

Importance of the red reflex examination at the 6 week check (with thanks to Dr Sarah Prentice)

Any blockage of light to the retina interferes with the development of optic neural pathways and can have profound effects on later vision.

The Examination

Darkened room
Ophthalmoscope on +3 dioptres
Hold 1 foot away

Red reflexes can only be described as normal if they are equal in colour, intensity and clarity with no opacities or white spots⁽²⁾

Handy hints

For the child that won't open his/her eyes: try picking/sitting them up or rocking them from sitting to lying. Having a parent hold them on their shoulder (as if winding them) and looking from behind often works. A feeding child will often open his/her eyes, although breast feeding then makes looking in the eyes logistically tricky.

Children with darker skin tones may have pale retina. If retinal vessels can be seen and followed to the disc and the reflex is equal bilaterally then this is reassuring. Comparison with parents red reflexes may also help.

Management:

Normal: No further follow-up. Will have routine ophthalmology review by school nurse/orthoptist in pre-school years.⁽⁵⁾

Unable to see red-reflexes or unsure: Referral to paediatric ophthalmology primary care clinic (if available)

Absent red reflex: Urgent referral to paediatric ophthalmologists (should be seen in less than 2 weeks). [See images.](#)

Family history of neonatal eye disease e.g. retinoblastoma, congenital cataracts: Routine referral to paediatric ophthalmologists.

Low birth-weight/premature infants: Should have had retinopathy of prematurity screening and follow-up arranged as necessary by neonatal unit.

See <http://www.paediatricpearls.co.uk/2011/02/checking-the-red-reflexes/> for further information, references and links to useful resources.



This month's featured NICE guideline: ADHD. Diagnosis and Management of ADHD (Attention Deficit Hyperactivity Disorder) in children, young people and adults. *Publ. Sept 2008*

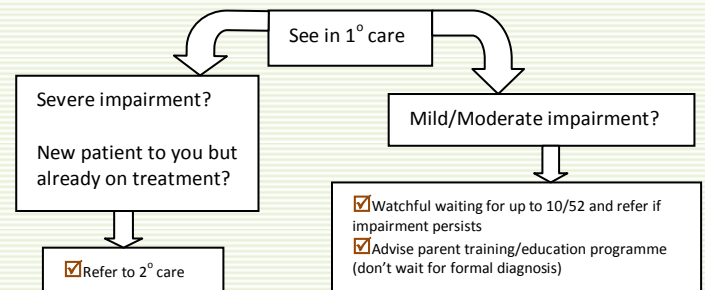
<http://guidance.nice.org.uk/CG72>



"ADHD is a heterogeneous behavioural syndrome characterised by the core symptoms of **inattention, hyperactivity and impulsivity**. Not every person with ADHD has all of these symptoms - some people are predominantly hyperactive and impulsive; others are mainly inattentive. Symptoms of ADHD are distributed throughout the population and vary in severity; only those people with **at least a moderate degree of psychological, social and/or educational or occupational impairment in multiple settings** should be diagnosed with ADHD. Determining the severity of ADHD is a matter for clinical judgement, taking into account severity of impairment, **pervasiveness**, individual factors and familial and social context."

<http://www.nice.org.uk/nicemedia/live/12061/42107/42107.pdf>

For the purposes of this guideline, children are aged 3 – 11, young people aged 12 – 18 and adults are >18. The care pathway begins in schools or primary care but **children should not be diagnosed or have treatment started by their GP.**



Much of the rest of the guideline pertains to secondary and tertiary care services and care of adults. **Drugs are not recommended in pre-schoolers but are the 1st line treatment in school age and older.** GPs may share monitoring and prescribing with 2° care services. The guideline includes:

- Information about specific drugs and side effects to look out for
- Advice after diagnosis eg. effect (or non-effect) of different foods
- Principles of respect, understanding and consent

There is information on local parent training/education programmes and ADHD referral pathways available at <http://www.paediatricpearls.co.uk/2011/02/attention-deficit-hyperactivity-disorder/>. **Please refer suspected ADHD cases to your local CFCS/CAMHS service; they are not seen in general paediatric outpatients.**

New guideline!

Prolonged jaundice

Physiological jaundice tends to reach peak levels between 4 and 7 days in full term babies and 7-10 days in the pre-term. It is not unusual for babies to still be visually icteric at 2 weeks of age especially if they are breast fed. Infants with prolonged jaundice are usually well and in our area the community midwives are responsible for organising the initial "prolonged jaundice screen".

Their protocol and investigations sheet is available at <http://www.paediatricpearls.co.uk/2011/02/lets-try-and-keep-prolonged-jaundice-out-of-a-and-e/>. GPs can use the same proforma if the baby no longer has a midwife; **please do not send these well babies to A and E.**

The rarer babies with prolonged *conjugated* jaundice (direct bilirubin >25µmol/L +/- pale stools) need investigating quickly as the outcome from biliary atresia is better if surgery takes place by about 6 weeks of age. Please discuss any concerning babies with **the attending consultant on the GP advisory line between 1100hrs and 1300hrs Monday to Friday.**

From the literature: Children who snore

Mouth breathing in a well child is associated with adenotonsillar hypertrophy - the main cause of obstructive sleep apnoea (OSA) among children. Ask about snoring at night, apnoeic episodes when asleep, waking at night and related somnolence/lethargy during the day. OSA can also result in behavioural and learning disorders so the authors advise early referral to ENT services. A retrospective cohort study found from 248 patients, 58% were primary snorers and 42% had OSA. The most prevalent ENT findings were adenotonsillar hypertrophy (61.2%), tonsillar hypertrophy (6.8%), adenoid hypertrophy (14.9%), rhinitis (62.5%) and secretory otitis (14.5%).¹

Braz J Otorhinolaryngol. 2010 Oct;76(5):552-6. (Full article at http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1808-86942010000500003&lng=en&nrm=iso&tlng=en)