Paediatric Pearls

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

Common myths about immunisation:

Myth: As your child has a cold you should postpone immunisations until he gets better
Truth: Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation.
Myth: Premature children (<37 weeks) should receive immunisations when they are 2 months corrected age
Truth: Premature infants should receive immunisations when they are 2 months chronological age.
Myth: Pertussis vaccination can cause epilepsy and febrile convulsions and brain damage.
Truth: Newer acellular pertussis vaccine causes fewer reactions and there is no evidence that it is linked in any way with brain damage.
Myth: MMR causes autism
Truth: Numerous comprehensively conducted studies have produced conclusive evidence that there is no link between the MMR vaccine and autism.
Myth: Single vaccines are as effective as the MMR vaccine.
Truth: Single vaccines are not available in the NHS for the following reasons:

- There is no source of licensed single measles or mumps vaccine in the United Kingdom
- Fewer children would complete the full course, leaving more children unprotected against the diseases
- Separate injections have to be given over an extended period, leaving children unprotected during this time and thus susceptible to infection. They are very likely to infect younger siblings too young to be vaccinated themselves.

For full details refer to Green Book updated version 16/5/2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_126898.pdf

I have posted Dr Rajashree Ravindran's (checked by Dr Christine Sloczynska) helpful synopsis of childhood immunisations on the website for anyone who feels they need a quick update. Do leave comments and/or questions.

Remember *Good Medical Practice* issued by the GMC? They have recently issued a similar (downloadable) 52 page long document called *0-18 years: guidance for all doctors*.

Some highlights from **Making Decisions**:

- You can provide medical treatment to a child or young person with their consent if they are competent to give it, or with the consent of a parent or the court. You can provide emergency treatment without consent to save the life of, or prevent serious deterioration in the health of, a child or young person.
- You should involve children and young people as much as possible in decisions about their care, even when they are not able to make decisions on their own.

And on **Parental Responsibility**:

- Mothers and married fathers have parental responsibility. So do unmarried fathers of children registered since 15 April 2002 in Northern Ireland, since 1 December 2003 in England and Wales and since 4 May 2006 in Scotland, as long as the father is named on the child's birth certificate.
- Unmarried fathers whose children's births were registered before these dates, or afterwards if they are not named on the child's birth certificate, do not automatically have parental responsibility.
- Adoptive parents have parental responsibility, as do those appointed as a child's testamentary guardian, special guardian or those given a residence order. Local authorities have parental responsibility while a child is subject to a care order.
- People without parental responsibility, but who have care of a child, may do what is reasonable in all the circumstances of the case to safeguard or promote the child's welfare. This may include step-parents, grandparents and childminders. You can rely on their consent if they are authorised by the parents. But you should make sure that their decisions are in line with those of the parents, particularly in relation to contentious or important decisions.

NICE's UTI guideline was reviewed in May 2011 and no changes made.

"Do not do recommendation":
For infants and children aged 6 months and older with first-time **UTI** that responds to treatment, routine ultrasound is not recommended unless the infant or child has an **atypical UTI** (seriously ill; poor urine flow; abdominal or bladder mass; raised creatinine; septicaemia; fails to respond to treatment with suitable antibiotics within 48 hours; infection with non-E. coli organisms).

So please ensure a urine sample is sent to the lab or you will miss an atypical UTI.

Find out all about a project that aims to enhance awareness of brain tumours in children at http://www.headsmart.org.uk/.

Nearly 10 children/week are diagnosed with a brain tumour but in the UK it can take up to 3 times longer than in the States to get a diagnosis.

Get a detailed history including

- New and persistent headache: wakes a child from sleep, occurs on waking, child under 4years of age, confused or disorientated
- Visual symptoms and signs: must have full visual assessment
- Persistent nausea and vomiting
- Motor symptoms and signs: regression, focal weakness, abnormal gait, dysphagia, Bell's palsy not improving by 4 weeks
- Growth and development
- Lethargy

Predisposing factors include family history of brain tumour, leukaemia, sarcoma or early onset breast cancer, previous CNS irradiation, neurofibromatosis, tuberous sclerosis, other familial genetic syndromes.

Indications for brain scan are discussed in a new RCPCH endorsed guideline. It is important to reassess all children to check improvement as the above symptoms and signs can mimic common childhood conditions. Symptoms can resolve, fluctuate and recur and do not exclude a brain tumour. Normal neuro examination does not exclude a brain tumour either.

Click here for the updated list of breastfeeding drop-in groups as of June 2011