Paediatric Pearls

GP update November 2010

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

BRONCHIOLITIS....

...is a lower respiratory tract viral infection affecting predominantly the under 1s that can cause fever, dry cough, nasal discharge and bilateral fine inspiratory crackles ± wheeze. November to March is peak bronchiolitis season. More background information and a link to the Map of Medicine on bronchiolitis is available from http://www.nhs.uk/conditions/Bronchiolitis/Pages/Introduction.aspx

A podcast on bronchiolitis is available at http://empem.org/2010/09/bronchiolitis-part-1-of-2/comment-page-1/#comment-294

There are no therapies that have been consistently effective enough to change the current supportive management of bronchiolitis. The majority of trials show that bronchodilators do not provide benefit and their routine use is not recommended (Current therapies in bronchiolitis. Petruzella FD, Gorelick MH *Pediatr Emerg Care* 2010 Apr;**26**(4):302-7).

A longer version of this article is available at http://www.paediatricpearls.co.uk/2010/11/bronchiolitis-season/

6- 8 week baby check series

This month sees the launch of our 6-8 week check series. Every month one of the paediatric trainees will be highlighting one or two aspects of this early child health surveillance thereby building up a store of information on www.paediatricpearls.co.uk to point you in the right direction when you find something that needs following up. Please do put a comment on the site if there are topics you are keen that we cover. There is a nice overview of the 6 week baby check at http://www.patient.co.uk/doctor/Six-Week-Review-(CHS).htm

This month's featured NICE guideline: *Nocturnal Enuresis (October 2010)* http://guidance.nice.org.uk/CG111

This is a very welcome guideline which should ensure that all children up to the age of 19 years who wet the bed receive similar advice and management plans.

It is built on the premise that there are 3 different, but sometimes interrelated, physiological disturbances implicated in bedwetting:

1. Sleep arousal difficulties
2. Polyuria
3. Bladder dysfunction

The 20 page quick reference guide available at http://www.nice.org.uk/nicemedia/live/13246/51382/51382.pdf is easy to follow with some clear management algorithms.

DO...

☑ Take a focussed history using suggested questions as per Table 1 to establish which of the above physiological disturbances is/are affecting the child's continence
☑ Perform urinalysis if there are any signs or symptoms suggestive of a UTI or diabetes mellitus
☑ Recommend support groups eg. www.eric.org.uk
☑ Address excessive or insufficient fluid intake or toileting habits prior to starting other treatment. Avoid caffeinated drinks.
☑ Use reward systems for rewarding previously agreed behaviour eg. drinking the right amount of fluid during the day or helping to change the sheets at night. Do not just reward dry nights.
☑ Consider an alarm or drug treatment (see algorithms in the quick reference guide for guidance on doses and how long to try different approaches for)
☑ Refer children on if they have not responded to treatment with an alarm and/or desmopressin

DO NOT....

☒ Condone punishment of children who wet the bed
☒ Exclude the under 7s on the basis of their age alone
☒ "Lift" the child late at night to wee except as a practical measure in the short term management of bed wetting
☒ Routinely measure weight, serum electrolytes, blood pressure or urine osmolality in children on desmopressin

The parent/patient information document is worth a read at http://www.nice.org.uk/nicemedia/live/13246/51369/51369.pdf to find out what NICE is expecting us to tell the patient and family!

There are further resources to do with enuresis including the Waltham Forest referral form at http://www.paediatricpearls.co.uk/2010/11/enuresis/

6-8 week check: heart murmurs (*with thanks to Dr Tom Waterfield*)

Most murmurs detected at the 6-8 week check will not be due to significant congenital heart disease but they should all be referred for further assessment and it is important to identify those children that need to be seen urgently. Innocent murmurs are systolic and are associated with normal weight gain, normal feeding and an otherwise normal clinical examination. This child can be referred routinely to paediatric outpatients or a paediatric cardiologist and the parents reassured that the murmur is likely to be due to the normal flow of blood around the heart. If there are any worrying features (diastolic murmur, impalpable femoral pulses, breathlessness, faltering growth) please discuss the child with the paediatric registrar on call.

http://kidshealth.org/parent/medical/heart/murmurs.html# is one of the top American sites on children's health aimed at the general public. It provides balanced information in clear English about heart murmurs for parents who are worried that their GP has heard one incidentally on examining their child.

For Tom's whole article and links to more resources about heart murmurs please go to http://www.paediatricpearls.co.uk/2010/11/heart-murmurs/