Paediatric Pearls

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Antipyretics

Fever is the body's way of fighting off an infection ie. it is not a bad thing in itself. We should treat the child, not their temperature. The main messages of the NICE fever guideline (www.nice.org.uk/CG47) are:

- *Do not give antipyretics routinely*
- *Do not give paracetamol and ibuprofen together*
- *Do not give antipyretics to prevent febrile convulsions*
- *Do give the family advice on where and when to seek further help*
- *Do be aware that it is possible to make a child look better with antipyretics when they are, in reality, septic. NEVER OVERLOOK PERSISTENT TACHYCARDIA!*

The model at Whipps Cross is that **children are seen initially by Emergency Department doctors** and referred to paediatrics if the ED middle grade or consultant feels it to be necessary. **Paediatricians see children formally referred by phone by their own GP** or those already seen by the **EUCC GP**. There is a paediatric consultant available to give telephone advice to local GPs between **11am and 1pm** Monday to Friday. Please ask switchboard for the "attending consultant". Urgent cases still need to be referred to the paediatric registrar in the usual way please.

FROM THE LITERATURE:

Tinea capitis (scalp ringworm) is a common fungal infection in inner city areas especially, but not exclusively, in children of Afro-Caribbean extraction. Children can present with a kerion (boggy ulcer-like lesion), scattered pustules, alopecia with broken off hair stubs or diffuse scaling of the scalp. Scrapings or brushings and hair pluckings should be sent to the lab before starting treatment which needs to be SYSTEMIC (eg. griseofulvin tablets) for 6-8 weeks. Microscopy results take about a week, culture significantly longer. Oral itraconazole and terbinafine are used but are still not licensed in children. Shampoos possibly reduce spread amongst household members but do not eradicate the tinea on their own.

Higgins EM et al. British Journal of Dermatology 2000;**143**:53-58 . Guideline available from the arguably inappropriately acronymed British Association of Dermatologists:
www.bad.org.uk/Portals/_Bad/Guidelines/Clinical%20Guidelines/Tinea%20Capitis.pdf

Clinical question

Do you normally prescribe antibiotics to wheezy children?

No, I don't. There is a clear review of this topic available in full text on line (http://pediatrics.aapublications.org/cgi/reprint/117/6/e1104) written by A L Kozyrskyj et al in 2006. Between 15 and 25% of children with a wheeze do get antibiotics (mainly from older GPs or those who have trained overseas according to the authors) but actually 80% of asthma exacerbations in the UK are caused by respiratory viruses and guidelines state that antibiotics are unnecessary in the treatment of acute asthma.

We follow our own asthma guideline which is based on the frequently updated SIGN/BTS guideline. The asthma one is at www.sign.ac.uk/pdf/sign101.pdf and, for bronchiolitis, look at www.sign.ac.uk/pdf/qrg91.pdf. Both state that antibiotics are not indicated in the management of wheezy children.

It is unusual for a wheezy child to have a significant fever. In these cases you would need to look for an alternative source of the high temperature.

This month's featured NICE guideline: *The epilepsies. The diagnosis and management of the epilepsies in adults and children in primary and secondary care (www.nice.org.uk/CG20, 2004).* Guideline currently under review and due for publ. 2011

The paediatric quick reference guide (www.nice.org.uk/CG020childrenquickrefguide) covers children from 28 days of age to 17 years. There is supplemental information on the management of epilepsy in pregnancy as well.

DIAGNOSIS

- Take a detailed history of the event from the child and an eye-witness
- Ask the family to video an event on their mobile phone
- All children with a recent-onset suspected seizure should be seen within 2 weeks by a clinician with training in the epilepsies (this will be a general paediatrician at Whipps who can refer on to an expert after baseline assessment +/- investigations if appropriate)

EEG is neither sensitive nor specific

- Use after the second fit to *support a diagnosis* of epilepsy in a child in whom the clinical history is suggestive
- Do not use it to *exclude* epilepsy if the history suggests syncope instead
- Should be done within 4 weeks of request (Whipps Cross children go to Great Ormond Street Hospital for EEGs)

MRI/CT

- Can be used to identify structural abnormalities
- Are not routinely requested when a diagnosis of idiopathic generalised epilepsy has been made

Other tests

- Consider blood and urine tests to determine underlying causes
- Consider an **ECG** if there is diagnostic uncertainty

TREATMENT

- Should be initiated by someone trained in the management of epilepsy and they should also plan the continuation of treatment (usually for at least 2 seizure-free years) and provide guidance for the withdrawal of treatment
- Anti-epileptic drugs (AEDs) are usually recommended after the 2nd fit. The quick reference guide features a very useful table of all the AEDs, their indications (dependent on the type of epilepsy) and side effects
- Children who fit for 5 minutes or have 3 fits in one hour should have emergency treatment in the community with rectal diazepam or buccal midazolam