Paediatric Pearls

GP update January 2011

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

Blue inhaler v. Brown v. Purple v. Green v. Orange…???...

NICE (2000) recommended that children under 5 needing inhalers should always use a metered dose inhaler (MDI) and spacer. In 2002 they stated that inhaled steroids were best administered via the same route for 5-15 year olds but that the choice of devices for bronchodilators (relievers) for this age group could be widened. We now have a bewildering plethora of different coloured, shaped and activated devices available to prescribe. When a child says they take 1 puff of the purple one and 2 of the blue, what does that mean?

The various inhalers (including what colour they are) are described at http://www.patient.co.uk/health/Inhalers-for-Asthma.htm

I have put together a reference table and other resources at http://www.paediatricpearls.co.uk/2011/01/inhalers-for-asthma/

There are animated clips of how to use the various devices at http://www.asthma.org.uk/health_professionals/interactive_inhaler_demo/

New on www.paediatricpearls.co.uk

We have published agreed paediatric reference ranges for basic blood tests as requested by the Out of Hospital Care group. See http://www.paediatricpearls.co.uk/2011/01/blood-test-reference-ranges/

Take a look at the Parenting resources page at http://www.paediatricpearls.co.uk/parenting-resources/ put together with our liaison health visitor. It is growing like topsy and not very user-in-a-hurry friendly so we suggest you browse through it at your leisure so you know roughly what is on it when a patient/parent seems to need signposting. Lots of links to parenting courses, information on sleep and behaviour, suitable health sites for teenagers, special needs drop in groups and respite care etc., etc. Please do add more resources that you know about to the site using the "comments" facility or you can e-mail me.

This month's featured NICE guideline: *Head Injury. Triage, assessment, investigation and early management of head injury in infants, children and adults (www.nice.org.uk/CG56 Sept 2007)*

20 page quick reference guide available at http://www.nice.org.uk/nicemedia/live/11836/36257/36257.pdf

This guideline is primarily written for first responders and ED staff and the ED version of January's Paediatric Pearls has more details for anyone interested.

In case you are assessing a child in your surgeries or EUCC with a recent history of a head injury, NICE lists the following indications for a head CT:

- Witnessed loss of consciousness lasting > 5 minutes
- Amnesia (antegrade or retrograde) lasting > 5 minutes
- Abnormal drowsiness
- 3 or more discrete episodes of vomiting
- Clinical suspicion of non-accidental injury
- Post-traumatic seizure but no history of epilepsy
- Age > 1 year: GCS < 14 on assessment in the emergency department
- Age < 1 year: GCS (paediatric) < 15 on assessment in the emergency department
- Suspicion of open or depressed skull injury or tense fontanelle
- Any sign of basal skull fracture (haemotympanum, 'panda' eyes, cerebrospinal fluid leakage from ears or nose, Battle's sign)
- Focal neurological deficit
- Age < 1 year: presence of bruise, swelling or laceration > 5 cm on the head
- Dangerous mechanism of injury (high-speed road traffic accident either as pedestrian, cyclist or vehicle occupant, fall from > 3 m, high-speed injury)

Any child who has a GCS < 15, neck tenderness, a focal neurological deficit, paraesthaesia in their extremities or any other suspicion of a cervical spine injury should be immobilised on a spinal board.

NICE has also recently published **3 public health guidelines on the prevention of unintentional injury** in the home, on the roads and during outdoor play and leisure. The quick reference guide to all 3 of these is at http://www.nice.org.uk/nicemedia/live/13274/51741/51741.pdf

6 week check series: Undescended testes (cryptorchidism) with thanks to Dr Sara Waise

- Check whether testes are:
  - Present or absent
  - In the inguinal canal
  - High in the scrotum
  - Able to be brought down into the scrotum
- Identify any other congenital defects
  - May be isolated
  - Can occur as part of genetic or endocrine disorders
- If the testes remain undescended at 1 year of age, referral to a urologist is needed.
- Early correction maximises future fertility potential
  - Outcome is poorer for bilateral undescended testes
  - Unclear whether surgical correction fully normalises this
- Surgical correction reduces malignancy risk
  - Facilitates self-examination
  - Risk remains 5-10 times greater than normal following orchidopexy

True **bilateral** undescended testes need immediate referral!

http://www.patient.co.uk/health/Undescended-Testis.htm provides a useful, printable overview for parents of boys in whom you have found an undescended testis.

http://www.patient.co.uk/doctor/Undescended-and-Maldescended-Testes.htm has information for medical professionals and includes information about the ascending testis syndrome in the older child.

Other topics within our 6 week check series available at www.paediatricpearls.co.uk

References
Kurpisz,. M., Havryluk, A., Nakonechnyj, A., Chopyak, V. & Kamieniczna, M. (2010). Cryptorchidism and its long-term consequences. *Reproductive Biology* **10** 19-35
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