Paediatric Pearls

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Put together by: Dr Julia Thomson, Consultant Paediatrician, julia.thomson@bartshealth.nhs.uk

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

NICE's advice on care of babies with prolonged jaundice (2010):

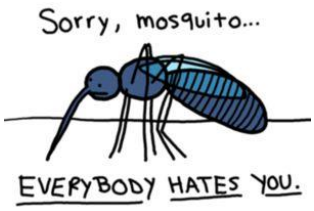
In babies with a gestational age of 37 weeks or more with jaundice lasting more than 14 days, and in babies with a gestational age of less than 37 weeks and jaundice lasting more than 21 days:

- ☞ look for pale chalky stools and/or dark urine that stains the nappy *
- ☞ measure the conjugated bilirubin *
- ☞ carry out a full blood count *
- ☞ carry out a blood group determination (mother and baby) and DAT (Coombs' test). Interpret the result taking account of the strength of reaction, and whether mother received prophylactic anti-D immunoglobulin during pregnancy
- ☞ carry out a urine culture
- ☞ ensure that blood spot test has been performed *

Follow expert advice about care for babies with a conjugated bilirubin level > 25 micromol/litre because this may indicate serious liver disease *

Pathological prolonged jaundice is rare and Barts Health has reduced the initial screen - *in a clinically well baby* - down to just the points with the *. These tests and checks can be done by midwives or GPs. Please do call paediatrics for advice if you are concerned and refer babies to us if they have results outside the parameters on this results sheet.

It is holiday season in the UK – watch out for MALARIA in returning travellers and visitors. **Non-specific symptoms of malaria**



- ✈ Fever/sweats/chills
- ✈ Malaise (vague discomfort)
- ✈ Myalgia (muscle pain, tenderness)
- ✈ Headache
- ✈ Diarrhoea
- ✈ Cough

Major features of severe or complicated mal

- 💧 Impaired consciousness or seizures
- 💧 Respiratory distress / acidosis (pH <7.3)
- 💧 Hypoglycaemia
- 💧 Severe anaemia
- 💧 Prostration (inability to sit or stand)
- 💧 Parasitaemia >2% red blood cells

✈ there are 1300-1800 cases of imported malaria per year in the UK with 2-11 deaths.
✈ 75% are *Plasmodium falciparum*. Usually admitted to hospital as deterioration can be sudden.
✈ No typical clinical features; always think of it in unwell returning travellers*

*Full text of updated 2016 UK guidelines on malaria treatment available here. Lalloo DG, Shingadia D et al. *Journal of Infection* (2016) **72**, 635-649

Guidance on how to interpret malaria tests in children available here and see next month's Paediatric Pearls newsletter for a summary by one of the authors.

SAFEGUARDING SLOT: Child Sexual Exploitation (CSE)

Sexual exploitation affects thousands of children and young people every year. The child is usually not aware it's happening. An intoxicated 13-year-old I saw in the ED this month after she had run away from a house her friends were still at, was shocked by my talk of grooming, sexual bullying and CSE – concepts that she had never heard of before. Parents should look out for:

- unexplained gifts
- changes in mood
- going missing
- staying out late
- being secretive about where they are going
- lack of interest in activities and hobbies
- missing school.

Click here for Barnado's short video for parents on spotting the signs of CSE and for their downloadable leaflets for parents and young people.

Take a look at the Wud U app from Barnado's. Designed to educate young people about the dangers of sexual exploitation. I wish I'd known about it for my vulnerable patient a couple of weeks ago.

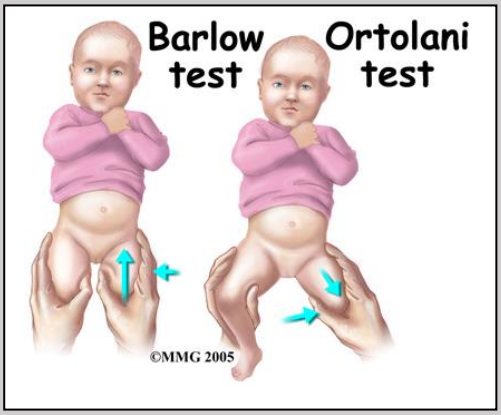
Could this be sepsis? – this is a "must read" guideline

NICE published their guideline on sepsis this month (NG51). It covers adults and children. The algorithms and risk stratifications for the under 5s mirror the fever guideline (CG160) but the algorithms for older children are new. Selection of links below:

☑ children under 5 out of hospital and in hospital
☑ children aged 5 to 11 years out of hospital
☑ children and young people aged 12 to 17 out of hospital

There are also risk stratification tools for:
☑ children under 5
☑ children aged 5 to 11 years
☑ adults and children and young people aged 12 years and over

More in the next few months on NG51



Developmental dysplasia of the hip – with thanks to Miss Natasha Picardo-Green

➢ Dysplastic hip is the most common orthopaedic disorder of newborns (1 in 100)

➢ Risk factors include: female sex, first born, breech, oligohydramnios

➢ Spectrum of disease ranges from shallow acetabulum to subluxation, dislocation and irreducible hip.

Examination in babies under 3 months:

Barlow – dislocates a dislocatable hip by adduction and depression of flexed femur
Ortolani – relocates hip by elevation and abduction of flexed femur
Galeazzi – with hip and knee flexed at 90^0, femur appears short on dislocated side

Examination in babies and children over 3 months:

Contractures have occurred therefore limited hip abduction, leg length discrepancy
Late signs: oblique pelvis, lumbar lordosis, Trendelenburg gait, toe walking

Diagnosis:
➢ by ultrasound before 4-6 months of age
➢ radiographs after 4-6 months of age (as femoral head has ossified)

Early treatment:
➢ Pavlik harness in first 6 months of life

Failure of early treatment/ late diagnosis:
➢ closed/ open reduction in theatre and spica casting or osteotomy.

More information:
http://emedicine.medscape.com/article/1248135-overview

Images: www.concordortho.com