Paediatric Pearls

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

3 PEOPLE PER DAY DIE FROM ASTHMA IN THE UK. MORE ON DIAGNOSIS, CONTROL AND EMERGENCY MANAGEMENT OVER THE NEXT FEW MONTHS. BTS/SIGN 2014

"If my child's having symptoms, please never send them to get their inhaler. Take the inhaler to them."
http://www.asthma.org.uk/advice-school

The BTS/SIGN guideline was updated in 2014 and is available here. There is more emphasis on supported self-management and on organisation and delivery of care. Asthma UK has some great empowering information for parents of children with asthma to share with their primary and secondary school children's teachers. Control is always better when people have a written plan in place. Click here for the Asthma UK child action plans to fill in with the family. Families can talk to an asthma nurse specialist about their child's asthma diagnosis by calling the Asthma UK Helpline on **0300 222 5800** (9am - 5pm; Monday - Friday).

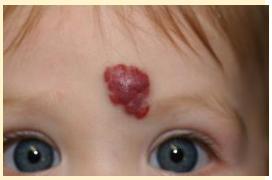
Capillary haemangioma / strawberry naevus

I saw a young baby this week with a rapidly growing strawberry naevus above their ear which had appeared around 2 weeks of age. Mum was unconvinced by my attempt to reassure that it would get a bit bigger and then involute on its own and be gone by the child was 7 - 9 yrs old (http://patient.info/doctor/strawberry-naevus). Was there nothing that could be done to stop it growing now, before it got even bigger?

Here's the information from the Birthmark Support Group:

- B-blockers (propranolol orally, timolol topically) – rapid ⇩ in size
- Steroids – largely been replaced by aforementioned B-blockers
- Laser therapy – specialist dermatology clinic
- Surgery – leaves a scar
- Bleomycin injections – response rate 77%

But the majority of lesions need no therapy. 6 monthly photographs may help to reassure. Refer only if lumbosacral, ulcerated, or if affecting breathing, feeding or vision (latter is urgent as amblyopia can occur in a matter of weeks).



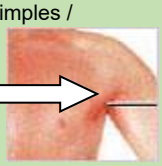
Parent information leaflet from Great Ormond Street Hospital here

Scarlet fever with thanks to Dr Andrew Lock, RLH dermatology SpR

- bacterial illness caused by strains of toxin releasing group A strep
- often presents with a rash due to the toxin
- usually occurs in children aged 2-8 yrs
- airborne/droplet spread or close contact + asymptomatic carriers
- incubation period: several days
- a notifiable disease in the UK (see PHE link below)

INITIAL SYMPTOMS: fever, sore throat, lymphadenopathy, headache, malaise, "strawberry tongue", myalgia

RASH: appears 1-2 days after the fever: starts with scarlet spots which later merge to give a "sunburn" appearance with goose pimples / "sandpaper like" feel. **OTHER SKIN SIGNS**:
- Fragile capillaries can rupture in skin folds (lines of petechiae termed "pastia lines" in axillae and groin
- Untreated, the fever takes up to a week to resolve. The rash will start to fade 5-7 days after the start of the Illness, skin will desquamate over the next few weeks.



DIAGNOSTIC TESTS: Throat swab from posterior pharynx / ASO titre

TREATMENT: penicillin for 7-10 days. Simple emollients for the rash.

COMPLICATIONS: Scarlet fever usually follows a benign course but untreated infection can uncommonly lead to early complications like otitis media and sinusitis, (rarely) rheumatic fever / glomerulonephritis.

NICE clinical knowledge summary: http://cks.nice.org.uk/scarlet-fever

Useful practical guidance from Public Health England: https://www.gov.uk/government/collections/scarlet-fever-guidance-and-data

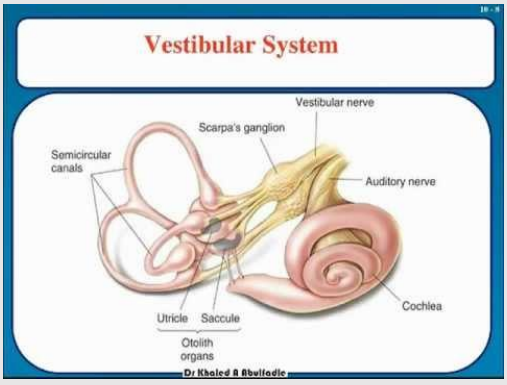
Patient information at http://patient.info/health/scarlet-fever-leaflet. Keep children off school for 24 hours after starting antibiotics.

ENT slot with Mr Sunil Sharma

Paediatric dizziness

= unsteadiness, imbalance, clumsiness, light-headedness and/or vertigo (illusion of movement)

Great website covering paediatric vestibular disorders: http://vestibular.org/pediatric-vestibular-disorders



Causes:
- ☞ Otitis media with or without effusion, cholesteatoma, vestibular neuronitis
- ☞ Benign paroxysmal vertigo in children (BPV) – aged 2-12, associated with migraines (including abdominal migraine), not same as BPPositionalV which is much less common in children
- ☞ Ototoxicity (e.g. gentamicin)
- ☞ Congenital (e.g. CHARGE, Usher, branchio-oto-renal (BOR) syndrome, Pendred)
- ☞ Others: Trauma, Cardiovascular (e.g. long QT syndrome), Neurological (e.g. epilepsy), Metabolic (e.g. electrolyte disturbance), Ocular (e.g. strabismus), Psychological (anxiety, panic)

History:
- ☞ Quality of symptoms: light-headedness, fatigue, inattention, rotation
- ☞ Duration: brief episode (BPV/epilepsy), hours (migraine/Meniere's), days (vestibular neuronitis)
- ☞ Duration of overall complaint
- ☞ Severity of symptoms over time; reducing with vesitibular compensation (BPV, vestibular neuronitis), fluctuating but not reducing (migraine)
- ☞ Triggers; head movement (BPV), motion sickness (migraine), stress and bullying (psychological causes), food (migraine), loss of awareness (epilepsy)
- ☞ Associated symptoms (e.g. ear symptoms)

Examination:
- ☞ Gait and play
- ☞ Home video recordings
- ☞ Ear examination
- ☞ Dysmorphic features (e.g. CHARGE and BOR)
- ☞ Oculomotor examination (eye movements, nystagmus)
- ☞ General paediatric examination and developmental examination (cardiovascular pathology, neurological and endocrine disorders)
- ☞ Dix-Hallpike and cerebellar examination (in older children)

Refer to ENT if suspected otological cause