Paediatric Pearls

September 2012

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

Chronic Fatigue Syndrome (CFS/ME): diagnosis and management in adults and children, August 2007 (http://guidance.nice.org.uk/CG53)

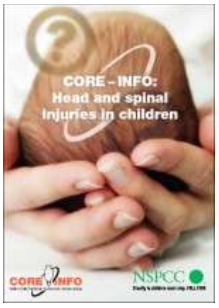
There will be up to 40 patients with CFS/ME in a GP practice of 10,000 patients. It is a clinical diagnosis and primary healthcare workers should be able to identify the characteristic features:

Consider the possibility of CFS/ME if a young person has a new-onset 3 month period of post-exertional malaise, reduced activity level and fatigue with one or more of the following features:
- difficulty with sleeping (insomnia, hypersomnia, unrefreshing sleep, disturbed sleep–wake cycle)
- multi-site muscle and/or joint pain without inflammation
- headaches
- painful lymph nodes without pathological enlargement
- sore throat
- cognitive dysfunction (poor concentration and short-term memory, difficulties with word-finding, organising thoughts and information processing)
- physical or mental exertion making symptoms worse
- general malaise or 'flu-like' symptoms
- dizziness and/or nausea
- palpitations in the absence of identified cardiac pathology

Refer to CAMHS, liaise with social care and educational services and be cautiously optimistic about prognosis in young people.
http://www.nice.org.uk/nicemedia/live/11824/36190/36190.pdf

Child abuse and head and spinal injuries

With thanks to Dr Su Li for summarising the Core-info leaflet on head and spinal injuries in children. Full details at www.core-info.cardiff.ac.uk.



This leaflet summarises what is currently known about the clinical presentation of inflicted head and spinal injuries in children. It is estimated that 1 in 3000 babies under 6 months suffer brain injury from shaking and/or impact injuries. Some die, 31-45% of survivors have on-going problems such as epilepsy, learning difficulties, CP.

Signs of inflicted head injury:
- loss of consciousness, fitting, paralysis, irritability
- subtle features: poor feeding, excessive crying, increasing OFC
- clues: retinal haemorrhages, rib and other fractures, bruising to the head and/or neck, apnoeas, other injuries: bites, oral injuries.

Management: refer to the paediatric registrar or consultant
- neuro-imaging to be performed in any infant (under 1 year) with abusive injuries and any child (> 1) with abusive injuries *and* signs or symptoms of brain injury. Findings may include subdural haemorrhages +/- subarachnoid haemorrhages (extradural haemorrhages are more common in *non-inflicted* injuries).
- examine thoroughly including ophthalmology and skeletal survey
- are there co-existing spinal injuries? (Neck injuries most common < 4mths, chest and lower back injuries more common > 9mths.)
- any child with an *unexplained* brain injury needs a full investigation eg. for metabolic and haematological conditions, before a diagnosis of NAI can be made.

Dr Li's full summary - with neuroradiological illustrations - is available at http://www.paediatricpearls.co.uk/2012/09/child-abuse-and-head-injuries/

Welcome to Paediatric Pearls!

August and September have seen the junior doctors change around again. Welcome to paediatrics and the Emergency Department (ED) if you have just joined us. Good luck if you are also just starting out in primary care. I have put below links to some of the highlights and essential topics on www.paediatricpearls.co.uk. Do contact me if you want to get involved!

Useful for ED doctors:
Emergency formulae: http://www.paediatricpearls.co.uk/2011/02/new-apls-guidelines-are-sort-of-here/
Initial assessment: http://www.paediatricpearls.co.uk/2010/09/a-quick-but-comprehensive-assessment-of-the-non-specifically-unwell-child-in-the-ed/
Asthma assessment: http://www.paediatricpearls.co.uk/wp-content/uploads/ED-June-2011.pdf
NAI fractures: http://www.paediatricpearls.co.uk/2012/08/fractures-in-child-abuse/
NAI bruising: http://www.paediatricpearls.co.uk/wp-content/uploads/May-2012.pdf
Rehydration in D and V: http://www.paediatricpearls.co.uk/2012/05/oral-rehydration-guideline/
Bronchiolitis: http://www.paediatricpearls.co.uk/2010/11/bronchiolitis-season-with-thanks-to-amutha-for-this-article/

Useful for GPs:
Constipation: http://www.paediatricpearls.co.uk/wp-content/uploads/gp-june-2010.pdf
Enuresis: http://www.paediatricpearls.co.uk/wp-content/uploads/GP-november-2010.pdf
UTI: http://www.paediatricpearls.co.uk/wp-content/uploads/gp-feb-march-2010.pdf
Normal blood values: http://www.paediatricpearls.co.uk/2011/01/blood-test-reference-ranges/
Limping child: http://www.paediatricpearls.co.uk/2011/05/limping-child-guideline/
Breastfeeding pitfalls: http://www.paediatricpearls.co.uk/2011/08/common-breastfeeding-problems/
Vitamin D deficiency: http://www.paediatricpearls.co.uk/2011/08/vitamin-d-guidance-at-last/
Antibiotics in self-limiting respiratory tract infections: http://www.paediatricpearls.co.uk/wp-content/uploads/ED-December-2010.pdf
Steroids in eczema: http://www.paediatricpearls.co.uk/wp-content/uploads/ed-may-2010.pdf
Milks in cows' milk protein allergy: http://www.paediatricpearls.co.uk/2011/02/faltering-growth/

And much, much more! Use the tag cloud or search function on the website to find out if a topic you are interested in has been featured and let me know if it has not.

The **Children's Acute Transport Service (CATS)** is a paediatric intensive care transport team serving around 50 hospitals in the North Thames, Essex, Herts, Beds, and East Anglia regions in England. They have a new website! See http://site.cats.nhs.uk/.

Useful features:
~ Prescription chart with in-built drug calculator (**NEW**. Find it under the "In a Hurry?" tab)
~ CATS clinical guidelines (useful if CATS are going to transfer the child. Please refer to local guidelines for initial management plans of paediatric emergencies)
~ Maps and travel directions for each of the PICUs to which they transport
~ Referral form (so you have the answers to the transport team's questions to hand...)
~ Education and training

Simple motor tics

"Tics are sudden, involuntary movements that serve no purpose except to frighten and worry parents. About 10% to 25% of otherwise healthy children, usually boys five to 12 years of age, develop these abnormal movements." (http://www.kidsgrowth.com)

- Motor tics include facial twitching, grimacing, blinking, shrugging of the shoulders
- Common phonic tics include coughing, grunting, clearing the throat, sniffing
- Most tics start during childhood and usually improve without treatment during the teenage years. Trying to stop the tic is like trying to hold back a sneeze.
- Some factors can make tics worse: anxiety, stress, tiredness
- 1 in 100 children in the UK have Tourette's syndrome. Here, tics usually begin around six years of age, often becoming more severe until 10 to 12 years old. Further reading:
  http://www.nhs.uk/Conditions/Tics/Pages/Introduction.aspx
  http://www.patient.co.uk/doctor/Gilles-de-la-Tourette's-Syndrome.htm (professional reference)
  http://www.patient.co.uk/health/Tourette's-Syndrome.htm (patient/parent information)
- CAMHS psychologists can help children cope with debilitating tics