

Paediatric Pearls

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A reminder about referring children to paediatrics....

Children coming to Whipps Cross A and E front entrance (EUCC) are seen first by a GP or senior nurse streamer. Injuries are streamed to paediatric A and E as are any children that the paediatric registrar has notified reception are "expected" ie. referred directly by GPs in the community. If the streamer thinks any other child is sick enough to come down to paediatric A and E, unless the triaging paediatric nurse is also worried, that child will see a junior Emergency Department doctor ie. someone with considerably less experience than a GP. Unfortunately, despite its name, paediatric A and E is not staffed by paediatricians so if you want a child seen urgently by a paediatrician, please speak directly to the paediatric registrar via the switchboard before the child arrives. **A letter on its own is not enough** (except for GPs working a shift in EUCC who do not have to call the registrar first). The attending (on-call) paediatric consultant is also available via switchboard from 11am to 1pm Monday to Friday to answer any clinical queries from GPs and can facilitate urgent outpatient appointments if that is deemed more appropriate than a trip to A and E. Please use the Choose and Book system to refer a child to children's outpatients if you think they can wait 2 weeks.

FROM THE LITERATURE: Transient loss of consciousness and syncope in children and young people: what you need to know

Syncope is a transient loss of consciousness resulting from an insufficient supply of oxygen to the brain and characterised by rapid onset, short duration, and spontaneous complete recovery. Up to 15% of children will experience at least 1 episode before the age of 18 and a population based study suggested the causes were vasovagal (75%), cardiac disease (10%), psychogenic or unexplained (8%) and epilepsy (5%). The key to diagnosis is in the history. A video of the event is invaluable, a 12-lead ECG mandatory, blood sugar and postural BP monitoring helpful. An EEG should not be requested in children in whom the most likely diagnosis is syncope as the results are potentially confusing and can lead to a misdiagnosis of epilepsy. Martin K et al, *Arch Dis Child Educ Pract Ed* 2010 Jun;95(3):66-72

A full text link to the updated European Cardiology Society's syncope guidelines for adults and children is available at <http://tip.org.pl/pamw/issue/article/446.html> (click on "EN" for the PDF version in English).

Does tongue-tie really affect breastfeeding? Who do I refer to?

A thick, tight or short sub-lingual frenulum is found in 3-4% of babies; lactation consultants strongly believe that a proportion of them cause feeding difficulties. Frenulotomy is a low risk minor procedure performed without anaesthetic but should be done by an appropriately trained person. Suckling efficiency improves anyway over the first few days and weeks and babies should not be referred too early; the diagnosis rests on observation and analysis of feeding, not the tongue's static appearance. Babies should not be routinely examined for tongue-tie but it should be considered if there are feeding difficulties.

Hall DMB, Renfrew MJ. Tongue Tie. *Arch Dis Child* 2005 90:1211-15
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1720236/pdf/v090p01211.pdf>

NICE (<http://guidance.nice.org.uk/IPG149>) has produced guidelines on division of tongue tie and acknowledges that the little evidence there is does seem to suggest that division can improve breastfeeding with no major safety concerns.

In this area, the frenulotomies are done by Mr Patel, paediatric surgeon at King's College Hospital. Referrals should come via a trained breastfeeding advisor (NCT, La Leche League and Breastfeeding Network all have active counsellors in Waltham Forest) as Mr Patel expects them to be appropriately assessed prior to referral to him and to be followed up by a feeding specialist afterwards.

Please note that not all tongue-ties cause feeding problems and there is no evidence to suggest that frenulotomy prevents later speech problems.

This month's featured NICE guideline: *The management of bacterial meningitis and meningococcal septicaemia in children and young people younger than 16 years in primary and secondary care* (CG 102, published June 2010 (amended July 2010))

available at www.nice.org.uk/guidance/CG102

Meningococcal disease is still the leading cause of infection-related death in children in the UK. This is a good practice guideline for GPs and clinicians working in Emergency Departments. It covers children with suspected meningitis (any bacterial cause), septicaemia and also those with petechiae (with and without fever).

The quick reference guide has some easy-to-follow algorithms:

- 1) pre-hospital management of suspected meningococcal disease and bacterial meningitis
- 2) bacterial meningitis pathway
- 3) meningococcal disease pathway
- 4) management of petechial rash

Selected pre-hospital points:

- ◆ Children with a fever or history of fever and unexplained petechiae need blood tests and to be observed for 4-6 hours as a minimum action.
- ◆ Patients commonly present with non-specific signs and may have a blanching rash initially or no rash. The pre-hospital algorithm lists common and less common specific and non-specific signs and symptoms of septicaemia and meningitis.
- ◆ In suspected meningococcal disease give im or iv benzylpenicillin (unless this will delay urgent transfer to hospital) and call 999 as children can deteriorate quickly.

Selected secondary care points:

- ◆ Lumbar puncture is indicated in suspected meningitis but note the contraindications.
- ◆ Give dexamethasone to children > 3 months with meningitis before antibiotics if possible, or within 4 hours of first antibiotics. Do not give high doses in meningococcal sepsis, nor in suspected tuberculous meningitis.
- ◆ Antibiotics can be ceftriaxone or cefotaxime and length of treatment and choice of antibiotic depends on the identified organism and age of the child.
- ◆ Shocked children may need a lot of intravenous fluid to stabilise them.

Selected long term points:

- ◆ Children need follow-up, hearing tests within 4 weeks and urgent referral for cochlear implant assessment if their hearing has been affected.