Paediatric Pearls

by Dr Julia Thomson, Paediatrician

March 2022

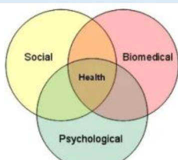
Monthly paediatric update newsletter for all health professionals working with children – put together by Dr Julia Thomson, Paediatric Consultant at Homerton University Hospital, London, UK. Housed at www.paediatricpearls.co.uk where comments and requests are welcome!

We all have feelings of being sore, feeling sick or having a headache sometimes.

MEDICALLY UNEXPLAINED SYMPTOMS

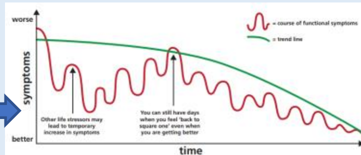
Functional symptoms are physical symptoms without an obvious cause. The current term for this is Medically Unexplained Symptoms or MUS.

"Everyone can have physical symptoms such as painful or uncomfortable feelings inside the body. Usually they get better on their own, and if they do not, we might ask the doctor about them. Often a reason for them can be found, but sometimes it cannot, even after the doctor has done a range of tests. If the symptoms continue and get in the way of everyday life we call these Functional Symptoms (FS) or Medically Unexplained Symptoms (MUS). Functional symptoms are common – one in four children has them – and almost everyone has experienced unexplained physical symptoms such as dizziness, headaches, or tummy aches."



https://media.gosh.nhs.uk/documents/Functional_symptoms_F2324_A5_col_FINAL_Jun20.pdf is a well written empathetic document written for families. It talks about Predisposing, Precipitating, Perpetuating and Protective factors within this biopsychosocial model.

The good news is that functional symptoms wax and wane but can get better over time.



MUS can overlap with FII. Doctors should not add to the child's anxieties by doing unnecessary tests or documenting no longer relevant diagnoses.

Page 15 of the RCPCH guidance on Fabricated and Induced Illness (FII), acknowledges our unease but warns us against over-medicalising.

Kawasaki?

With thanks to Dr Johnnie Pass for updating us on atypical KD after we had 2 cases in quick succession on the ward, one less than a year old.

Kawasaki disease

1.2.26 Be aware of the possibility of Kawasaki disease in children with fever that has lasted 5 days or longer. Additional features of Kawasaki disease may include:

- bilateral conjunctival injection without exudate
- erythema and cracking of lips; strawberry tongue; or erythema of oral and pharyngeal mucosa
- oedema and erythema in the hands and feet
- polymorphous rash
- cervical lymphadenopathy. [2019]

1.2.27 Ask parents or carers about the presence of these features since the onset of fever, because they may have resolved by the time of assessment. [2019]

1.2.28 Be aware that children under 1 year may present with fewer clinical features of Kawasaki disease in addition to fever, but may be at higher risk of coronary artery abnormalities than older children. [2019

A reminder on **typical** KD from NG143 – Fever in under 5s

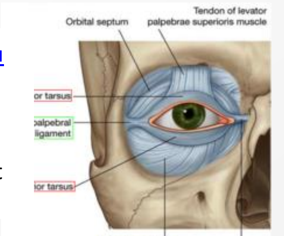
- please think about KD in any infant under 1 yr with fever ≥ 5 days. They are high risk for coronary artery aneurysms.
- older children with at least 2 of the criteria to the left might have **atypical** KD
- NSAIDs should be avoided in KD
- defer live vaccines until 11 months post ivIg treatment for KD.

https://www.kawasakidiseaseuk.org/kawasaki-disease for more information.

"Did you know?"

That most children with periorbital cellulitis can be managed at home on oral antibiotics?

https://www.paediatricpearls.co.uk/periorbital-and-orbital-cellulitis-in-children/ has more information on the difference between orbital and periorbital cellulitis and why it matters in children.



Authors of a recent survey of paediatric emergency departments*, published in EMJ, reported that, although 90% of clinical practice guidelines advise discharge with oral antibiotics for milder cases, 86% of respondents reported departmental admission of all patients with periorbital cellulitis.

*Tolhurst-Cleaver M, Evans J, Waterfield T, et al Periorbital and orbital cellulitis in children: a survey of emergency physicians and analysis of clinical practice guidelines across the PERUKI network *Emergency Medicine Journal* Published Online First: 09 March 2022. doi: 10.1136/emermed-2021-211713

NICE 2019 (NG141): Cellulitis and Erysipelas – antimicrobial prescribing suggests 7 days oral co-amoxiclav - or clarithromycin if penicillin allergic. Refer if systemically unwell or eye not getting better after 48 hours. Parental advice from Healthier Together is good (but mentions 10 days' antibiotics).

I make no apology for copying The Child Bereavement Trust's recent mailshot about educational opportunities for everyone working with bereaved children. These courses are excellent value for money and very pertinent for the world in which we currently find ourselves:

- We are very pleased to launch our 3-hour online workshop ***Asylum Seeking families – the impact of loss grief and bereavement*** this month, with another scheduled for May. This session comes at a very important time as we see an increase in families seeking asylum due to the events in Ukraine. This 3-hour session is designed to help those who work within this area - including those within the education, health, social care and voluntary sector.
- Our 90-minute webinar ***Having honest conversations about death in schools*** may also be appropriate for those working in education at a time when students might be asking difficult questions about death. Please see below.
- The 3-hour interactive training sessions are delivered by experts in their field, with plenty of opportunity for discussion and reflection. Training costs £45 and is aimed at any professional who works with grieving children and young people, in any capacity.
- April sees the launch of our new ***Schools - an introduction to grief and bereavement*** webinar. This 90-minute course is suitable for professionals working in nurseries, schools, colleges and other educational settings. Cost is £22.15.
- If you have a number of staff and would like dedicated bespoke training please get in touch (training@childbereavementuk.org) to discuss your needs. We can deliver training virtually or face-to-face and can contextualise the content to suit your situation and needs.

Do you know what "puddle jumping" is, in the world of a grieving child?
Have a look at https://www.childbereavementuk.org/puddle-jumping.

The overlap between ASD and ADHD, with thanks to Dr Saika Mazhar

DSM-5 describes how people with ADHD show a persistent pattern of inattention and/or hyperactivity and impulsivity (from before age 12) **that interferes with functioning or development.**

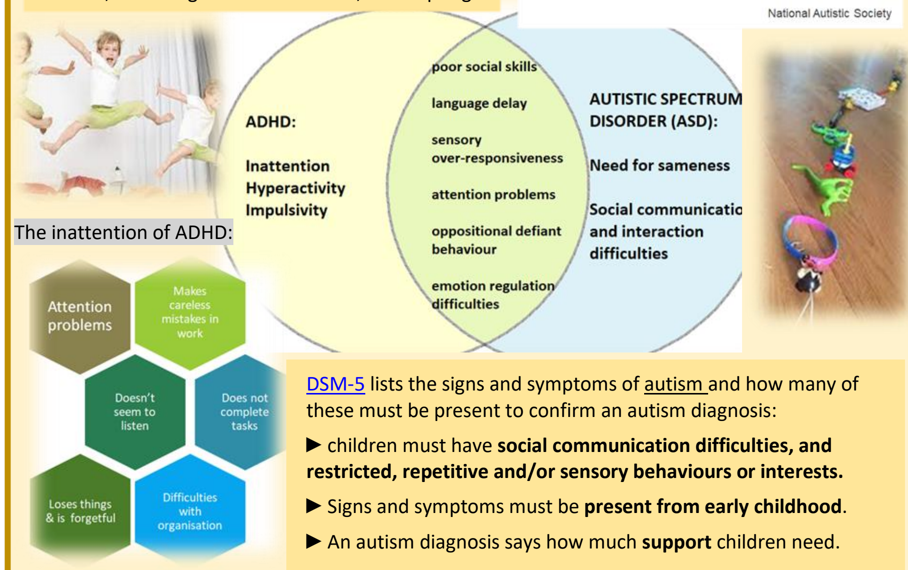
Signs include: fidgeting, squirming, leaving seat, running about, talking excessively, blurting out answer, not being able to await turn, interrupting.

What is ASD?

"An autism spectrum disorder is a lifelong developmental disability that affects the way a person communicates and relates to people around them."

"It's really easy to think that the autism is like a shell around your normal child and that if you try hard enough you'll get that outer shell off, and your child will be free to get on. But you have to realise that it's not something in the way of them being normal, it's part of them."

National Autistic Society



The inattention of ADHD:

DSM-5 lists the signs and symptoms of autism and how many of these must be present to confirm an autism diagnosis:

▶ children must have **social communication difficulties, and restricted, repetitive and/or sensory behaviours or interests.**

▶ Signs and symptoms must be **present from early childhood**.

▶ An autism diagnosis says how much **support** children need.