Paediatric Pearls

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

Resources on www.paediatricpearls.co.uk include:

Archive of all past Paediatric Pearls newsletters (GP and ED versions) with search function to enable you to find individual topics

Information (Parenting resources tab) on local service providers for all aspects of parenting, obesity, free nursery places, teenage pregnancy, respite care.

Comments from specialists on topics featured in the newsletters. Read what the paediatric ENT surgeon said on sleep apnoea or the paediatric allergist's take on severe cows' milk protein allergy.

It takes me ages to put together – please use it!

Pulled elbow: common in 1-4 year olds, can be recurrent, may not always be a history to go with it. Click here for further information and explanation with diagrams on how to reduce it. Ask the nurses in A and E to show you how to do it if unsure. Melbourne Hospital has a nice "child not using upper limb" flowchart.

Umbilical hernias

90% of **umbilical hernias** spontaneously resolve by 5 years of age. Less than 1% ever become incarcerated. Bandaging coins over the defect in the muscle wall is not helpful. Ask the parent to see the GP who can then refer to a paediatric surgeon at 3 years of age if still present. Click here for parent information and here for a Youtube video on how to do the operation (in an adult)!

Inguinal hernias are different. If the hernia is irreducible, discuss the child with the surgeons; they may need to go to the paediatric surgeons at RLH. Children with reducible inguinal hernias can be referred by their GP to Mr Brearley at Whipps Cross.

This month's featured NICE guideline: Depression in children and young people - identification and management in primary, community and secondary care *(Sept 2005, reviewed Feb 2011. http://guidance.nice.org.uk/CG28)*

See also http://www.cks.nhs.uk/depression_in_children which is a site affiliated to NICE and I think makes things clearer than the actual guideline.

Ask about key symptoms:
- ☑Persistent sadness or low mood, which may present as irritability
- ☑Loss of interest or loss of pleasure (anhedonia)
- ☑Fatigue or low energy

If any key symptoms are present, ask about other associated symptoms:
- ☑Poor quality, or increased need for, sleep
- ☑Poor concentration or indecisiveness
- ☑Low self-confidence
- ☑Poor or increased appetite
- ☑Suicidal thoughts or acts
- ☑Agitation or slowing of movements
- ☑Guilt or self blame

Mild depressive episode: persistent (at least 2 weeks) sadness or low mood (or irritability) with either anhedonia or tiredness, plus *two* associated symptoms.

Moderate-to-severe depressive episode: persistent sadness or low mood (or irritability) with either anhedonia or tiredness, plus *three or more* associated symptoms.

Severe depressive episode with psychotic symptoms if there is persistent sadness or low mood (or irritability) with either anhedonia or tiredness, plus *seven or more* associated symptoms plus psychotic symptoms.

GPs, paediatricians, school nurses, health visitors and voluntary agencies are all examples of a Tier 1 service. We have to refer the moderate and severe groups to CAMHS and also the mild ones who have not responded after 2-3 months, those with a family history of depression and where there is unexplained self-neglect for at least 1 month. Fluoxetine is sometimes prescribed by Tier 2-4 practitioners to the 12-18 year old age group in conjunction with psychological therapies (eg. cognitive behavioural or family therapy). It is continued for 6 months after remission is achieved (8 weeks symptom free) and then phased out over 6-12 weeks. Efficacy not established < 12yrs.

Only 10% recover spontaneously within 3 months. 50% are still clinically depressed after 1 year. There is a 3% risk of suicide over the next 10 years. More detailed background information in essay format in the 233 page full guideline for those who are interested. The patient information leaflet is at http://guidance.nice.org.uk/CG28/PublicInfo/pdf/English.

The regular use of antihistamines in children – think non-sedating!

1st generation antihistamines (eg Piriton) have sedative side effects as they are lipophilic, cross the blood brain barrier and have been shown to reduce learning function in children. 2nd generation antihistamines (eg. cetirizine, desloratidine) are lipophobic and cross the blood brain barrier less readily. A large scale surveillance study has shown that the degree of sedation of 2nd generation antihistamine is disease dependent.[1]

Cetirizine, as an example, has been shown to have favourable efficacy, tolerability profile, rapid onset of action, and did not have any adverse effects on cognitive function, behaviour or achievement of psychomotor milestones in paediatric patients. It was at least as effective as Piriton and loratadine.[2] Ng et al found that the mild sedating effects of Cetirizine may not always be subjectively perceived in children.[3]

Sedating antihistamines are occasionally useful when insomnia is associated with urticaria and pruritus. (cBNF) Click here to comment on this topic!

1. Izumi et al, Methods Find Exp Clin Pharmacol. 2008 30(3):225-30, **Analysis of disease-dependent sedative profiles of H(1)-antihistamines by large-scale surveillance using the visual analog scale.**
2. Curran MP et al Drugs. 2004;64(5):523-61. **Cetirizine: a review of its use in allergic disorders.**
3. Ng KH et al. Pediatrics. 2004 113(2):e116-21. **Central nervous system side effects of first- and second-generation antihistamines in school children with perennial allergic rhinitis: a randomized, double-blind, placebo-controlled comparative study.** http://pediatrics.aappublications.org/cgi/reprint/113/2/e116
4. Crido PR. An Bras Dermatol. 2010 85(2):195-210. **Histamine, histamine receptors and antihistamines: new concepts.** http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0365-05962010000200010&lng=en&nrm=iso&tlng=en