

Paediatric Clinical Pearls of Wisdom: "Things I wish I knew when I was a Junior Clinician..."

INFORMATION FOR CLINICIANS & HEALTH PROFESSIONALS



AIRWAY / BREATHING

- ❖ Grunting reflects significant respiratory or systemic illness in children and should never be discounted.
- ❖ All that wheezes is not asthma - think cardiac or foreign body if there is an asymmetrical wheeze.
- ❖ Beware of stridor that becomes softer. It may mean worsening upper airway obstruction rather than improvement. Assess for other signs of airway obstruction.
- ❖ If there are added respiratory noises, are they inspiratory or expiratory? Inspiratory is likely to originate from above the thoracic inlet, eg stridor. Expiratory are likely to come from below the thoracic inlet, eg wheeze.
- ❖ Consider lower lobe pneumonia in the differential diagnosis for abdominal pain in children.
- ❖ Effortless tachypnoea may be compensating for acidosis from shock, sepsis or diabetes. Look beyond the child's chest.



CIRCULATION

- ❖ Feel for an enlarged liver in children presenting with breathing problems. It is the best sign of heart failure in children.
- ❖ Pallor may be the only sign of compensated shock in a child.



DISABILITY / NEUROLOGY

- ❖ Neck stiffness may not be obvious in a child with meningitis, especially in children less than 3 years old.
- ❖ If you think of lumbar puncture, consider doing a lumbar puncture!
- ❖ Early morning or nocturnal headache with vomiting is secondary to raised intracranial pressure until proven otherwise.
- ❖ Changes in behaviour could be organic or psychological.
- ❖ Neonatal seizures are often subtle and are rarely tonic clonic due to immature neural synapses and myelination.



EXPOSURE (sepsis / infection)

- ❖ An isolated tachycardia may be the only sign of sepsis. Never ignore persistent tachycardia.
- ❖ Fine facial petechiae are often a benign consequence of crying, coughing or vomiting in young children. Non-blanching purple spots are more likely to have a serious cause if they are larger, below the chest or associated with a fever.
- ❖ Unexplained tachypnoea may reflect compensation for a metabolic acidosis and be a sign of developing sepsis.
- ❖ Sepsis should be in the differential diagnosis for every neonatal symptom and sign.
- ❖ In febrile children, the younger the child, the higher the likelihood of bacterial infection.
- ❖ The problem doesn't go away just because the fever does after anti-pyretics and the cause is no less likely to be serious if the fever does respond.
- ❖ Children less than 1 month of age with a temperature greater than 38°C should be admitted and have a full septic work up and treated with antibiotics.
Be cautious in those less than 3 months of age.
- ❖ Sepsis would be a differential in any significantly unwell child. If in doubt, administer antibiotics early. They can always be discontinued once the clinical picture is clear if needed.



FLUIDS / GLUCOSE / GASTROINTESTINAL

- ❖ Vomiting without diarrhoea is not gastroenteritis until significant alternatives have been excluded (e.g. UTI, meningitis, brain lesion etc.)
- ❖ Hypoglycaemia presents subtly in children. In any sick child, measure a Blood Glucose Level.
- ❖ Think about the wide differential diagnoses for hypoglycaemia carefully and consider doing critical bloods.
- ❖ Bilious vomiting is green and always has a surgical explanation.
- ❖ Always ask the colour of vomitus. Green vomitus indicates bowel obstruction until proven otherwise.



OTHER

- ❖ Conjugated hyperbilirubinaemia in any child is abnormal and requires investigation (> 20% of total bilirubin is in the conjugated form).
- ❖ The child of anxious parents can have real and serious pathology.
Listen to the parents/carers