

HOT TOPICS UPDATE

Paediatric RESPIRATORY

8-12 colds a year is NORMAL especially in winter months.

>10% post salbutamol improvement is significant.

Monteleukast can be helpful especially if child will not take inhaler. 10% will have bad dreams.

- Take chest pain SERIOUSLY
 - **Localized lateral acute chest pain in e.g. 5 year old – pathological. Should be admitted.**
 - Could represent pneumonia/effusion/pneumothorax.
 - Other causes: musculoskeletal after trauma [rib fracture, torn intercostal, bruising, costochondritis.
 - MUST document respiratory rate and pulse rate.
- All asthmatic children have cough – but not all cough will be due to asthma
 - **Habit cough: typically disappears at night** [all tests will be negative]
- Wheeze is usually asthma – but not always
 - Tracheal web:
 - Red flags:
 - Wheeze persistent
 - Wheeze sounded upper airway
 - No allergies
 - DDX:
 - Upper airway obstruction[subglottic stenosis/vocal cord dysfunction]
 - Asthma
 - Chronic lung disease

TRANSIENT ISCHAEMIC ATTACKS

50% of TIAs lasting only a few minutes can be assoc with infarction on diffusion weighted MRI

May have crescendo symptoms.

Duration is often <60 minutes

Cumulative risk at 7 days if 5.2%

Highest risk in first 24hrs

15-30% of ischaemic strokes have been preceded by TIA

ABCD2 scoring doesn't take into consideration previous stroke/TIA

Differential Dx:

- Migraine 12%: Younger. F>M
- Syncope: 2%: F>M
- Benign positional vertigo 1.6%
- Seizure: 1.2%
- Functional anxiety 1%

UROLOGY

- Prostatitis: Perineal pain. Painful erection. Pain on sitting on hard chairs.
- Torsion: testicle may lie horizontally
- Nitrites
 - Bacteria produce nitrite from nitrate
 - 4hours required for bacteria to convert nitrate to nitrite

- Nitrite positive in Enterobacteria and Gram negative organism – most common E colic 72%, Klebsiella and Proteus
- Nitrite negative in Staph saprophytic (upto 2%), Pseudomonas (upto 4%) and Enterococci (upto 12%)

GASTRO SURGICAL EMERGENCIES

- Appendicitis:
 - **Different to sudden onset seen with gyny causes**
 - Short history (1-2 days). Vague abdo pain which then localized to RIF.
 - NEW anorexia, nausea, vomiting, loose stools
 - EXCLUDE IBD – will not have long history of loose stools +/- bleeding/FH
 - **Early appendicitis typical temp<38 [unless perforated]**
 - Percussion tenderness
 - **Kids may have soft abdomen – do hop test**

Beware of pitfalls:

 - **May have coexisting microscopic haematuria**
 - Sigmoid diverticulitis
 - Caecal malignancy [check HB – preceding change in bowel habit- do colonoscopy]
- Diverticulitis
 - Usually left sided and tenderness with loose stools, fever
 - Complications: Perforation/Mass/Bleeding/Fistula [e.g. to bladder cause UTI/pneumaturia/faecaluria)

Beware pitfalls

 - Refer if not improving on oral antibiotics (augmentin and metronidazole)
 - Need to exclude underlying malignancy once settled
 - **arrange endoscopy in 2-3months**
 - if no fever suspect malignancy
 - if recurrent UTI – consider fistula and ask about pneumaturia
- Bowel obstruction

Admit all cases of bowel obstruction

 - Proximal small bowel obstruction (e.g. jejunum) early vomiting, less distension
 - Distal small bowel obstruction less vomiting, gross distension
 - Colonic obstruction with incompetent ileocaecal valve: vomiting++ distended++ but less pain in time
 - Closed loop large bowel obstruction i.e. competent ileocaecal valve: no vomiting, distended ++, **beware caecal tenderness [perforation could be imminent]**
- Ischaemic bowel
 - **Pain out of proportion to signs – very SEVERE abdo pain – can have normal feeling abdomen initially**
 - Consider risk factors
 - Bloody diarrhoea. WCC often >20 – or may be normal
- Epigastric pain

Consider peptic ulcer disease, pancreatitis,cholecystitis [can have similar clinic presentation]
History of NSAIDs,smoking,alcohol excess,gallstones,hyperlipidaemia

Rigidity/peritonitis implies perforation
- Anorectal emergencies
 - Abscess

Admit unless good history of fissure

 - Perianal/ischiorectal/intersphincteric
 - Pain/erythema/swelling/fever
 - Fissure

- Feels like “passing glass”
- Anal spasms after bowels open.
- If good history – treat and review in 3 weeks
- Thrombosed piles
 - Ice pack + analgesia
 - Refer if septic/portal vein thrombosis
- Irreducible rectal prolapse: use sugar granules [it reduces the oedema] and allow to reduce under firm pressure far more easily.

FOOT SURGERY

All foot surgery takes 6 months to recover but painful deformed foot which prevents mobilisation will inevitably get worse with time.

No point on operating on foot if not walking UNLESS the foot condition is life threatening

Examination: how does the skin look (is the deformity threatening the skin). Is there an adequate blood supply

Beware night pain [may represent osteomyelitis]