

Clinical Effectiveness Bulletin

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NHS WALSALL HEALTH AUTHORITY

Updating Health Professionals on Developments in Clinical Practice

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In 1998 obesity was designated as a global epidemic by the World Health Organisation.

Obesity treatment and prevention in children is vital as lifestyle behaviours are less well established and more amenable to change.

The prevalence of atopic eczema is increasing, affecting up to 15% of children.

In anticipation of the National Service Framework for Children, this years Annual Report by the Director of Public

Childhood obesity

Persistent obesity in children is associated with a number of diseases that may persist into adult life. Recommendations of approaches in primary care include:

- Clinicians need to know that obesity may be endogenous (genetic or endocrine) and they need to be aware of its complications in children.
- The primary goal of treatment is healthy eating, rather than restricting diet, and inculcating good habits of physical activity.

Atopic eczema in children

The following guidelines have been issued by NICE for the situations / conditions that should prompt referral to specialist services.

Health Medicine has focussed on children's issues.

As part of this ongoing programme this issue of the Clinical

Effectiveness Bulletin aims to address a number of areas of particular relevance to primary care.

- Parents who believe that obesity is inevitable or are not ready to make changes within the family may need counselling to make them more willing to cooperate.
- Treatment of overweight or obesity should begin early and involve the family.
- The aim should be for small, incremental changes in behaviour, with recognition of the need for ongoing support for families.
- Young obese children

should maintain weight or gain weight slowly rather than lose weight.

- Psychosocial problems are important consequences of overweight or obesity.
- Behavioural treatments should be individually designed.
- All treatments must be acceptable to the family.

Edmunds L, Waters E, Elliott EJ. Evidence based management of childhood obesity. *BMJ* 2001; 323: 916-9.

costeroids of appropriate strengths and quantities (see British National Formulary, Section 13.4; see also sec-

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Atopic eczema accounts for around one third of dermatological consultations in general practice.

Atopic eczema usually starts in the first years of life and clears by teenage years in over 60% of cases.

Presentation is typically as an itchy, patchy, erythematous rash, often with excoriation and bleeding.

Although treatment is not curative, it usually reduces symptoms and can considerably improve the quality of life of the child and family

Otitis media with effusion is the commonest cause of hearing loss in childhood. In half of those affected resolution occurs within 3 months, and in 95% within a year.

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tion 13.5) given for defined periods. Antibiotics are used for patients with suspected secondary bacterial infection and oral aciclovir for suspected herpes simplex infection. Bandaging (such as wet wraps or zinc paste) and sedative antihistamines are also used.

Referral to a specialist service, which may be prompted by features such as sleep disturbance and school absenteeism, is advised in the following circumstances:

Is seen immediately (within 24 hours)

- Infection with disseminated herpes simplex (eczema herpeticum) is suspected.

Is seen urgently (within 2 weeks)

- The disease is severe and has not responded to appropriate

therapy in primary care.

- The rash becomes infected with bacteria (manifest as weeping, crusting, or the development of pustules), and treatment with an oral antibiotic plus a topical corticosteroid has failed.

Is seen soon (within 2 months)

- The rash is giving rise to severe social or psychological problems.
- Treatment requires the use of excessive amounts of potent topical corticosteroids.

Has a routine appointment (ideally within 13 weeks)

- Management in primary care has not controlled the rash satisfactorily. Ultimately, failure to improve is probably best based upon a

subjective assessment by the child or parent.

- The patient or family might benefit from additional advice on application of treatments (e.g. bandaging techniques).
- Contact dermatitis is suspected and confirmation requires patch-testing (this is rarely needed).
- The child has uncontrolled eczema and dietary factors are suspected (refer directly to a dietician).

Referral Advice. A guide to appropriate referral from general to specialist services.

National Institute for Clinical Excellence, 2001.

Persistent otitis media with effusion in children

In the majority of children, the effusion and hearing loss will resolve spontaneously and management will remain within primary care.

Specialist services (e.g. hearing assessment, tympanometry) may be required to clarify the diagnosis.

Referral for an ENT opinion should take into account concerns raised by the child's parent, school or health visitor.

Children awaiting a routine outpatient appointment may need to be reassessed to check for clinical changes, and so the possible revision

of the referral time.

In children with persistent effusion, nothing worthwhile is gained by prescribing an antibiotic, decongestant or antihistamine. Parents should be informed that exposure to cigarette smoke worsens the outlook.

For those with persis-

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tent effusion, referral for an ENT opinion is advised in the following circumstances:

Is seen urgently (within 2 weeks)

- The otoscopic features are atypical and accompanied by a foul-smelling discharge suggestive of cholesteatoma.
- They have excessive hearing loss suggestive of additional sensorineural deafness.

Is seen soon (within 2 months)

- They have proven hearing loss plus difficulties with speech, language, cognition or behaviour.
- They have proven hearing loss plus a second disability, such as Down's Syndrome.
- They have proven hearing loss together with frequent episodes of acute otitis media.

Has a routine appointment (ideally within 13 weeks)

- They have proven persistent hearing loss detected on two occasions separated by 3 months or more (results of formal testing should be included in the referral letter).

Referral Advice. A guide to appropriate referral from general to specialist services. National Institute for Clinical Excellence, 2001.

Hearing loss is not always the presenting complaint and consultation may occur because of problems with speech and language development (this applies particularly to children aged under 4 years), or because of learning or behavioural problems and compromised levels of social function.

Urinary tract infection

PREVENTION

Likely to be beneficial

- Prophylactic antibiotics after first or subsequent UTI.
- Immunotherapy.

INVESTIGATION

Unlikely to be beneficial

- Routine diagnostic imaging in all children with first UTI.

TREATMENT

Beneficial

- 7–10 days of antibiotic

ics (better than shorter courses).

Likely to be beneficial

- Oral (rather than intravenous) antibiotics for acute treatment of children 2 years or younger with *normal* renal tracts or mild vesicoureteric reflux.

Unknown effectiveness

- Giving early empirical antibiotic treatment instead of awaiting the results of microscopy or culture.

- Oral antibiotics for the acute treatment of children 2 years or younger with *moderate or severe* vesicoureteric reflux. (*Intravenous antibiotics are preferable in children under 2 years with moderate or severe reflux.*)

Larcombe J. Urinary tract infection. Clinical Evidence 2001;6:320-9.

Boys are more susceptible to UTI before the age of 3 months; thereafter the incidence is substantially higher in girls.

Estimates of the true incidence of UTI depend on rates of diagnosis and investigation. At least 8% of girls and 2% of boys will have a UTI in childhood.

Recurrent sore throats in children

Most children have isolated episodes of acute sore throat (acute tonsillitis, acute pharyngitis), which can last up to 10 days and usually resolve spontaneously.

The definition of recurrence is arbitrary; here recurrence is defined as five or more episodes in the previous 12 months. The diagnosis of recurrence does not depend on the underlying cause

(viral, bacterial), or on the severity of the symptoms.

Advice should be given on keeping a 'sore throat diary' in or-

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Recurrent sore throat may interfere with school attendance, education and behaviour.

Systemic features such as fever, lethargy, malaise and vomiting may occur.

Findings on examination include redness and swelling of the tonsils or pharyngeal lymphoid tissue, with or without exudate. The child may also have swollen and tender cervical lymph nodes.

Specialist services are in a position to:

Confirm or establish the diagnosis.

Provide management advice.

Assess the need for and, if necessary, undertake surgery.

Treat complications.

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der to establish any pattern of recurrence and the impact on the child's day-to-day activities.

Clinical management aims to reduce the severity and duration of individual episodes and prevent complications such as quinsy (peritonsillar abscess).

For most patients, antibiotics have little effect on the extent and duration of symptoms.

Paradoxically, children treated early with an antibiotic may be at increased risk of further infection and may re-attend more often.

An antibiotic should be given, however, if the child has:

- Features of marked systemic upset secondary to the acute sore throat.
- Unilateral peritonsillitis.
- A history of rheumatic fever.
- An increased risk from acute infection (such as a child with diabetes mellitus or

immunodeficiency).

In those in whom an antibiotic is initially withheld, the position should be reviewed if the symptoms are worsening after several days. A post dated antibiotic prescription may be considered. Reasons for prescribing or withholding an antibiotic should be discussed.

There is no evidence to support the routine use of throat swabs.

A specialist opinion is advised in the following circumstances:

Is seen immediately (within 24 hours)

- They have, or are suspected of having, a quinsy.
- The swelling is causing acute upper airways obstruction.
- The swelling is interfering with swallowing, causing dehydration and marked systemic upset.

Is seen soon (within 2 months)

- They have a history

of sleep apnoea, daytime somnolence and failure to thrive.

Has a routine appointment (ideally within 13 weeks)

- They have had five or more episodes of acute sore throat in the preceding 12 months documented by the parent or clinician, and these episodes have been severe enough to disrupt the child's normal behaviour or day-to-day activity.
- They have guttate psoriasis which is exacerbated by recurrent tonsillitis.

Is seen within an appropriate time depending on his or her clinical circumstances

- There is suspicion of a serious underlying disorder such as leukaemia.

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National Institute for Clinical Excellence, 2001.

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