

# Medicine for Managers

Dr Paul Lambden BSc MB BS BDS FDSRCS MRCS LRCP DRCOG MHSM



## Is My Child Ill?

**For the average parent, there is nothing worse than a sick child. Trying to decide whether a child is ill and needs to see a doctor or is just unwell or off colour is always difficult. Making the decision is often equally difficult for a healthcare professional and so often minor symptoms herald a serious illness. Unfortunately everyone involved in paediatric care gets it wrong sometimes.**

There is no easy and foolproof way to assess just how unwell a child actually is and trying to assess whether the child has a minor viral illness or the first signs of something serious are a challenge for parents and clinicians alike.

NICE guidance on Feverish Illness in Children runs to 310 pages. However a few basic stages can often assist in making a clear and appropriate assessment of the child.

Much depends on whether and to what degree the child has a fever. The normal body temperature of a child varies between 36.5 and 37°C. There are various ways of measuring a temperature.

Taking the temperature in the mouth or the ear (aural thermometer) or in the anus will give a reliable result. Under the arm or using a thermosensitive strip on the skin will give a lower and less reliable reading.

When the parent brings the child to the GP, walk-in centre or A&E with a raised

temperature, it is therefore essential to understand what is happening. Questions should therefore be:

- What temperature readings have been obtained?
- How long has fever been present?
- How was the temperature measured?
- If paracetamol or ibuprofen brought the temperature down did the child appear better?
- What other symptoms have been noticed, e.g. nasal (cold) symptoms, respiratory symptoms, rash, earache, sickness or diarrhoea?
- Has the child's behaviour changed, e.g. become lethargic or clingy?
- Is the child sleepy?
- Has the parent noticed any change in the sound of the child's cry?
- Is there any history of convulsions (fits)

It is important to listen carefully to what the patients say. They may well be anxious and agitated but they do know their child best.

An unwell child may cease to feed normally. Maintaining hydration is important in a child and it may be best assessed by checking urinary output (regular wet nappies).

For the clinician this stage in assessing the child may be complicated by establishing the relationship with the family.

They may have concerns which extend beyond simply wanting to know that the child is OK or needs treatment. For the clinician, there should be an awareness of:

- Parents who are anxious about seeking advice
- Aggressive parents who may have experienced delay in obtaining treatment or felt fobbed off at a previous consultation
- Parents who want a particular outcome, such as an antibiotic
- Parents who are frightened
- Parents who believe that they will not be taken seriously

This means that the treatment will be the management of the child and possibly the family too.

It may be harder to make an assessment of the child when brought by a grandparent or an au pair.

Once as detailed as possible a history has been elicited, the child must be examined. The

examining clinician will look out for **intermediate risk** or **high risk** findings.

1. The temperature. If it is found to **be above 38°C in a child under 3 months** or **above 39°C in a child under 6 months** it should be treated seriously. Children over 6-12 months may present with high temperatures and the level alone should not necessarily be used as a sign of serious illness.
2. The activity and awareness of the child. If the child is unresponsive, floppy, not alert or with a strange cry, this may be a cause of serious concern.
3. Colour of skin and lips. Particularly of note are changes of pallor, mottling and blueness of the lips.
4. Respiration. Signs of concern are tachypnoea (rapid breathing) with grunting or wheezing and struggling to take in enough air. A harsh barking cough or whoop may also be significant. The chest should be examined with the stethoscope for signs of wheeze or infection.
5. The heart should be examined. The rate should not exceed 160/minute in a child of less than 12 months or 140 in a child between 2 and 4 years old. Increased rates (tachycardia) may indicate the heart under strain.

Both respiratory rate and cardiac rate will be increased by a high temperature.

The inspection will continue with examination of the throat, ears, any lymph gland enlargement and the skin for a rash.

The child should be fully undressed (inconvenient though that may be) whilst examining for a rash.

If any is present its nature and distribution should be recorded.

**The rash should be tested using a tumbler and meningitis should be considered in any rash which does not blanch on pressure (see below).**

Other signs to note are any swellings of any joints, or problems with bearing weight, neck stiffness or dislike of light.

For the clinician careful correlation of the symptoms together with consideration of the risk associated with each should then enable the consideration of specific diseases.

In many cases a raised temperature combined with upper respiratory symptoms, possibly a sore throat and perhaps loss of appetite or difficulty in feeding (because of nasal blockage) will indicate a viral infection which can be managed symptomatically.

For a small proportion, however, the symptoms and signs may suggest a more serious illness. Specific diseases that should be considered include:

- Meningitis. It should be considered the diagnosis until proven otherwise in any

child with a temperature and a **non-blanching** rash. It should be managed accordingly and referred to hospital promptly.

- Encephalitis. An infant or child with raised temperature, headache, impaired consciousness and convulsions should be considered to have encephalitis until proved otherwise. Again referral to hospital is a priority.
- Acute asthma. Respiratory distress, gasping wheezy respiration, pallor or blueness of the lips can suggest an acute asthma. Prompt treatment administered in the surgery may control and relieve the symptoms. Further management depends on response and the presence of complicating factors such as chest infection.
- Chest infection and pneumonia. Fever, breathlessness, sometimes with inspiratory stabbing pain (if pleurisy is present), blueness of the extremities and chest sounds with a stethoscope indicative of infection need treatment with antibiotic and antipyretic (drug such as paracetamol to reduce temperature) and, if the level of oxygenation is falling, admission to hospital.
- Acute infective arthritis. Characterised by an acute painful swelling, usually of one joint, with pain and reduced or absent movement. Such episodes are usually managed in hospital.
- Urinary infections. Children, particularly girls, may acquire urinary infections. Clues are pain on passing urine (dysuria), blood in the urine (haematuria) and an offensive smell. Rising temperature and abdominal pain may signal involvement of the kidney(s). Treatment is with antibiotic or

admission depending on severity and risk of damage to the kidneys.

- There are other less common infections too which may cause an acutely ill child.

So, when confronted by a poorly child with a temperature, looking miserable and possibly with other symptoms, the job of the clinician is to look for the serious case amongst the more minor, self-limiting viral illnesses that children incubate all the time.

The skill of picking up the one meningitis every 2-3 years amongst the variety of viral illnesses which may look similar and which occur every day is the challenge.

**Is it so surprising that a diagnosis is delayed or missed once in a while with this medical needle in a haystack.**

Napoleon said he wanted his generals to be lucky. I think there are several illnesses which appear occasionally (e.g. meningitis, malaria, tuberculosis) which are obvious once you know what they are but which need that degree of luck to recognise them.

**Pray for lucky doctors too!**

[paullambden@compuserve.com](mailto:paullambden@compuserve.com)