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GROWTH CHARTS AND MONITORING

*Hemchand K Prasad  
**Vaman Khadilkar

Abstract: Growth is a measure of well being in a given child. All pediatricians should follow the growth monitoring guidelines released in 2007. Measured growth should be plotted on IAP modified WHO charts in children less than 5 years and on IAP 2015 charts above 5 years. Standard guidelines of WHO and IAP should be used to measure and plot growth measures. The redefined target range, short stature and overweight cut-offs must be used to diagnose growth problems early. The new charts allow a pediatrician to plot the growth in accurate months. It is also colour coded to diagnose and alert families of children with obesity. The definitions of stunting, wasting, overweight and obesity in different ages are presented. Early recognition of these growth abnormalities is crucial for the long term health of the child.

Keywords: Growth charts, Growth monitoring, Adult equivalent.

Points to Remember

- A ‘growth reference’ is a comparison of the given child’s growth to the local population. A ‘growth standard’ is a concept of “what should be the growth in optimal conditions”.
- Usage of different growth charts and different cut-offs lead to different interpretation of the same anthropometric measure.
- All pediatricians should follow the IAP growth monitoring guidelines published in 2007.
- IAP recommends - IAP modified WHO charts in children less than 5 years and IAP 2015 growth charts in children more than 5 years.
- Key modifications in the new recommendations include - Lowered target range to ± 6 cm; new definition of overweight and obesity to 23rd and 27th adult BMI equivalent and definition of short stature to height < 3rd percentile.
- The new charts are user friendly - Colour coding for obesity; plotting can be done in accurate months (not decimal age).
- Once abnormal growth is recognised, calculating height and weight age or calculation of Z scores must be done for further evaluation.
- Specialised growth charts - Intergrowth and syndrome specific charts must be used in preterms and syndromic children, as appropriate.

References


H1N1 REVISITED

*Vidya Krishna

Abstract: Seasonal influenza is an acute febrile respiratory illness caused predominantly by Influenza type A (H1N1). Influenza, traditionally an under recognised disease, gained notice after the 2009 pandemic. In children, it can cause asymptomatic infection to severe illness and even death, particularly in infants and those with co-morbid conditions. This article will focus on the epidemiology of influenza and clinical aspects including clinical features, complications, diagnosis, treatment and prevention including chemoprophylaxis, vaccination and infection control measures.

Keywords: Influenza, H1N1, Children.

Points to Remember

- Influenza A (H1N1) is the major seasonal influenza virus.
- High risk groups include children under 5 years, immunosuppressed, those with chronic medical conditions, obesity, pregnancy and those aged >65 years.
- Testing for influenza is mandatory only for the hospitalized patients.
- Treatment should be started without delay in the high-risk groups and the complicated cases.
- Vaccination of the high-risk groups and healthcare workers should be done in September - October each year.

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SEDATION AND ANALGESIA IN OFFICE PRACTICE

*Mullai Baalaaji AR

Abstract: The number of diagnostic and therapeutic procedures performed outside the operating room are increasing. Sedation and analgesia is required to control child’s behaviour during the safe execution of an unpleasant procedure. The physiological characteristics of children make them vulnerable to the potential side effects of sedative agents. The key to provide safe procedural sedation involves choosing the right agent and anticipatory preparedness for any untoward event. Topical and locally acting agents along with non-pharmacologic interventions are useful adjuncts and help in reducing the sedative requirements.

Keywords: Pain management, Anesthesia, Analgesia.

Points to Remember

- Procedural sedation and analgesia (PSA) is a continuous process and involves titration of agents to the desired effect.
- Pre-sedation assessment includes focused history and physical examination of the child’s airways.
- The goals during PSA include sedation, anxiolysis, analgesia, motion control, amnesia and muscle relaxation and the choice of agents depends on the type of procedure and the intended need.
- Careful monitoring is vital during and after sedation with appropriate documentation.

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FINANCIAL LITERACY FOR DOCTORS

Thirumalai Kolundu S

Doctors vulnerability

Due to our hectic work schedule, lack of time to read financial magazines and reluctance to discuss financial matters with peers, doctors seldom possess adequate financial knowledge.

Moreover we easily succumb to the pressure of the bank people and investment agents who are mostly our patients or relatives and take wrong financial calls resulting in huge loss.

In order to avoid this, we must take basic training to become financially literate and can also engage a financial adviser registered under Securities and Exchange Board of India (SEBI) to manage our finance.

Need for financial prudence

Due to extended period of education, we settle very late in our life and start to earn only at the age of 30 to 35 years. Marriage and having a child are also delayed because of this. Even then when we start our life, we go for loans to buy a car, house, to set up a clinic and to buy instruments leading to heavy debt trap which takes away most of our income as interest. To overcome all these things, we must have adequate financial knowledge to optimise our investments to get good returns.

Finance advice in a nutshell

1. Start financial planning and retirement planning at an early age as soon as we start earning and not very late in life.
2. Save with discipline and innovation.
3. Take term insurance up to 8 to 10 times of your annual income.
4. Take health insurance for Rs 5 lakhs immediately after starting to earn and increase it to minimum of 10 lakhs after getting married and make the policy as family floater.
5. Invest 6 months equivalent of your expenses in liquid funds as emergency money which can be withdrawn within 24 hours. This will earn double the interest when compared to SB account.
6. Percentage of saving equivalent to your age should be in fixed-income instruments like debt funds, PPF, tax free bonds and fixed deposits (last).
7. For income tax exemption under 80c, best options are Equity linked savings schemes (ELSS) and Public provident fund (PPF).
8. Only 5% of portfolio should be gold and that too only as gold exchange traded fund (ETF). Jewels will have only ornamental value and will not serve as good investment.
9. Buy first flat without any hesitation but think twice before buying second one. Most of the time good mutual fund earns more than the real estate.
10. Investment in mutual funds are very important and should make up 50% of our portfolio. Instead of investing in multiple mutual funds, choose 4 or 5 mutual funds and invest under systematic investment plan (SIP). Our spread in mutual funds can be like this - Large cap funds 2 numbers, diversified funds 2 numbers and one mid cap fund.
11. Investment in shares requires lot of knowledge. When we don’t have time to read financial magazines, we can choose best 20 to 30 top performing companies in various sectors and buy 1 or 2 shares during every fall of SENSEX by 500 to 1000 points. Similarly we can buy Nifty BeES also during every fall of SENSEX. This will give a decent return of at least 15%. This will make us rich in a long time horizon.
12. Try to avoid high cost loans.
13. Try to use debit cards instead of credit cards. Credit cards favour uninhibited spending.

It is ideal to attain financial independence by the age of 55, so that we can enjoy life in travel, reading, writing and spending time with our family and lead a peaceful life.

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THROMBOCYTOPENIA

*Janani Sankar

Abstract: In an infant or child thrombocytopenia can occur due to large spectrum of illness ranging from tropical infection to malignancy or bone marrow failure. It is important to recognize signs and symptoms to identify the underlying illness which caused thrombocytopenia. Laboratory evaluation is essential to reach the diagnosis. Management is decided by the severity of thrombocytopenia, associated risk factors and underlying illness.

Keywords: Platelets, Bleeding.

Points to Remember

- Thrombocytopenia is defined as a platelet count of less than 150,000/microL. Spontaneous bleeding does not usually occur until the platelet count is less than 20,000/microL.
- Clinical presentation with cutaneous (eg, petechiae, non-palpable purpura, ecchymoses) and/or mucosal (eg, epistaxis, gingival bleeding, bullous hemorrhage, menorrhagia) bleeding are common while intracranial hemorrhage (ICH) is rare.
- Thrombocytopenia with systemic symptoms and/or the presence of lymphadenopathy or hepatosplenomegaly should raise suspicion for malignancy and should be evaluated expeditiously.
- Peripheral blood smear must be carefully examined for estimation of platelet number, morphology, presence or absence of platelet clumping and evaluation for associated white and red blood cell abnormalities.
- Bone marrow examinations generally are not required for the initial evaluation in most cases of unexplained isolated thrombocytopenia in children.

Bibliography


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LATE TALKING TODDLER—WHEN TO WORRY?

*Somasundaram A

Abstract: Late talkers are children who exhibit delay in language onset with no other diagnosed disabilities or developmental delays in other cognitive or motor domains. The primary objective is to differentiate them from other causes of speech and language delay. They may present with expressive language delay only or mixed expressive and receptive delay. Family history, male gender, lack of communicative interaction between parents and children are the known risk factors for late talking. It is appropriate to adopt ‘watchful waiting’ strategy with late talkers who have good comprehension and without any family history of language problems.

Keywords: Late talkers, Expressive speech delay.

Points to Remember

- Majority of late talkers do not have later language difficulties.
- A family history of language/literacy problems is a risk factor for persisting problems.
- A good clinical evaluation of the central nervous system, ear, nose and throat and audiometry are mandatory in all cases of suspected speech and language delay.
- Almost all kids with autism are late talkers - but not all late talkers have autism.
- ‘Watchful waiting’ strategy can be adopted in late talkers who have good comprehension and without family history of language problems.

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ELEVATED TRANSAMINASES IN A CHILD
- APPROACH

*Malathi Sathiyasekaran

Abstract: Elevated transaminases or transferases implies that the levels of serum glutamic pyruvic transaminase (SGPT) or alanine aminotransferase (ALT) and serum glutamic oxaloacetic transaminase (SGOT) or aspartate aminotransferase (AST) are more than twice the upper limit of normal and indicate hepatocyte injury. This may be detected incidentally in an asymptomatic child or be present in a symptomatic child with liver disease. The level of transaminases may be elevated both in acute and chronic hepatitis but is not an index of prognosis. In acute hepatitis the level may indicate the etiology and recovery whereas in chronic hepatitis it is used as a surrogate marker to monitor therapy.

Keywords: Transaminases, Transferases, Hepatocyte injury.

Points to Remember

- Elevated transaminases are markers of hepatocyte injury and do not indicate liver function.
- A child with elevated transaminases whether asymptomatic or symptomatic needs to be evaluated in detail.
- In acute hepatitis elevated transaminases may give some clue to etiology and indicate recovery when the level decreases.
- Transaminases are not a marker for prognosis in either acute or chronic liver disease.
- In chronic hepatitis B elevated transaminases helps in initiating therapy.
- Transaminase levels are used as a surrogate marker for monitoring therapy in both chronic hepatitis B and autoimmune hepatitis.

References


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HYPOPIGMENTED SKIN LESIONS – WHAT A PEDIATRICIAN SHOULD KNOW?

*Madhu R

Abstract: Hypopigmentation in a child, is of deep concern to the parents mainly owing to the social stigmatization and the belief that all hypopigmented lesions are either due to leprosy or vitiligo. Hypopigmentation may be congenital or acquired, localized or generalized, circumscribed or diffuse and may be due to infectious or non-infectious causes, with or without scales. It becomes important for the pediatrician to be well versed with the clinical presentation of the various common conditions associated with hypopigmentation. Four congenital causes of hypomelanosis and few acquired causes of hypopigmentation such as pityriasis alba, pityriasis versicolor, polymorphic light eruption, vitiligo, post-inflammatory hypopigmentation and leprosy will be discussed in this article.

Keywords: Hypopigmentation, Congenital, Acquired.

Points to Remember

- Hypopigmentation may be due to infections or non-infectious causes, with or without scales. It can be congenital or acquired, localized or generalized, circumscribed or diffuse.
- Reassurance, camouflage and masterly inactivity are the options in children with localised congenital hypomelanotic conditions – Nevus depigmentosus and nevus anemicus.
- Children with Hypomelanosis of Ito and tuberous sclerosis complex require evaluation for systemic associations.
- Common acquired hypopigmented conditions with scaling includes pityriasis versicolor, pityriasis alba and polymorphic light eruption.
- Hypopigmented patch of PMLE could be differentiated from pityriasis alba and pityriasis versicolor by the presence of itching after sun exposure and symmetrical distribution when present.
- Common acquired hypopigmented conditions without scaling includes leprosy, vitiligo and post-inflammatory hypopigmentation.

References


EARLY CHILDHOOD CARIES - CAUSES AND MANAGEMENT

*Muthu MS
*Ankita Saikia

Abstract: Early childhood caries is a disease affecting the primary dentition of children below six years of age. Previously, termed as 'nursing caries' or 'baby bottle caries', this disease has become endemic in all developed as well as developing countries. Although, there are numerous factors associated with this disease, night time feeding practices are strongly associated. This disease not only affects the child's teeth but also affects the overall health. Children with early childhood caries have been associated with poor quality of life. This disease is completely preventable when intervened by the first year of life.

Keywords: Caries, Children, Full mouth rehabilitation, Prevention.

Points to Remember

- Presence of caries in children below 6 years of age can be diagnosed as early childhood caries.
- First dental visit of a child must be as soon as the first milk tooth erupts or on their first birthday, whichever is the earliest.
- Early childhood caries can result in poor quality of life for the child. This can be reversed by full mouth rehabilitation. Consequences of not treating can lead to damage to permanent teeth as well as increased caries risk on permanent teeth.
- Full mouth rehabilitation under general anesthesia is one of the best methods for rehabilitation of multiple caries in children of pre-cooperative age.
- Measures like good oral hygiene practices, periodic fluoride application and periodic dental check up every 6 months can possibly prevent early childhood caries.

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HEAD INJURY IN CHILDREN - TRIAGING AND IMAGING

*Leema Pauline C  
**Viveka Saravanan  
**Ravi LA

Abstract: Head injury in infancy and childhood differ significantly from adults in the modes of injury, mechanisms of damage and the management of specific problems. Fall from height forms the most important cause of pediatric head injury. The overall outcome for children with head injury is better than that of adults with the same injury score but recovery takes a longer time.

Keywords: Head injury, Assessment, Management.

Points to remember

- Head injury remains the leading cause of death and disability in pediatric trauma victims.
- Fall from height is the most common cause of head trauma in children.
- Presence of fundal hemorrhages, fractures of various ages on skeletal survey, subdural hematoma in neuro imaging are clinical clues to suspect non accidental trauma.
- It is very important to prevent head injury in children and if it occurs, should be treated aggressively.
- Non contrast CT brain with bone window is the most useful imaging study in patients with head trauma.
- Maintenance of adequate airway, breathing and circulation would minimize the secondary brain injury.
- Prompt management of increased intracranial pressure, hypothermia, seizures and neurogenic pulmonary odema would significantly reduce the morbidity.
- The overall outcome for children with head injury is better than that of adults with the same injury scores.

References


TEN PITFALLS IN MANAGEMENT OF URINARY TRACT INFECTION

*Sudha Ekambaram
**Vaishnavi Raman

Abstract: Urinary tract infection (UTI) is a common disease in infants and young children. Infants present with fever. Children have associated urinary symptoms. Immediate diagnosis and appropriate therapy prevents renal scarring, hypertension and reduced renal function. This presentation will assist the treating pediatrician to identify top clinical pitfalls in managing UTI.

Keywords: UTI, pyuria, uroprophylaxis, investigations, antibiotics.

Points to Remember

- Early diagnosis and prompt treatment of UTI will reduce renal damage.
- Bag sample is not the method of choice for urine culture.
- Diagnosis of UTI is not based on a single factor but collective factors like symptoms, pyuria and urine culture.
- BBD is the common risk factor noted for breakthrough UTI.
- Uroprophylaxis is not a universal therapeutic choice.

References


ANTIARRHYTHMIC AGENTS

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Abstract: Symptomatic cardiac arrhythmias are relatively uncommon in childhood, accounting for about 5% of the emergency hospital admissions. Atrial tachyarrhythmias are the most common rate and rhythm disturbance in this population. With the advent of effective ablation therapy, management of arrhythmia has undergone dramatic change. A clear understanding of the mechanisms that initiate the rhythm disturbances and the various pharmacological agents that are used would enable optimal management of arrhythmias. Some of the agents that are licensed for use in children are discussed in this article.

Keywords: Arrhythmias, Action potential, Supraventricular tachycardia, Ventricular tachycardia.

References

MEDIASTINAL TUMOURS IN CHILDREN - AN INSIGHT

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Abstract: Common complaints for which children seek pediatric consultation are recurrent lower respiratory tract infection, wheeze, respiratory distress with or without fever and pneumonia. Pediatricians should be diligent to unmask a mediastinal tumour that may underlie a persistent or recurrent pneumonia. Chest X-ray in these children may give a clue for further evaluation. The earlier the diagnosis of mediastinal tumour is made, better the long term outcome. This review article highlights the common presenting features of mediastinal tumours and approach to their management.

Keywords: Bronchopneumonia, Mediastinal tumour, Thoracic neuroblastoma.

Points to Remember

- Persistent pneumonia in a child should be thoroughly investigated to unmask a mediastinal lesion.
- CT chest is an important first line investigation to evaluate a non-resolving chest opacity.
- Early diagnosis and total excision of mediastinal tumours will have a favourable outcome.
- Video assisted thoracic surgery will play a crucial role in evaluation and management of thoracic lesions.

References


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CASE REPORT

RECURRENT VAGINAL FOREIGN BODY - TWO MUCH PRANK

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Abstract: Vaginal foreign body is a common cause of vaginal bleeding in prepubertal girls. Recurrence in the absence of abuse is rare. Examination and ultrasound- abdomen of a six-year, eight month girl with history of two-week vaginal-bleeding and five-day fever revealed the presence of vaginal foreign-body. Child reported insertion of hairpin, diagnosed and removed. Treatment with gynecological, psychological evaluation and follow-up was successful.

Keywords: Recurrent vaginal foreign body, Children, Abuse, Vaginal bleeding

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