NHS

## General Paediatrics / Allergy / Primary Care

Effective: November 2017
Review: November 2020

# Management of Childhood Food Allergy (& cow's milk protein allergy)

- 6-8% of preschool children have food allergy.
- A personal or family history of atopy is the most significant predictor of allergy. Ask about history of the reaction, including timing and likely precipitants. Include eczema, asthma, history of Gastroesophageal reflux & family history of allergy or atopy.
- Note that the absence of signs or symptoms does not exclude a food allergy.
- There are 2 types of allergic reactions – Immediate (IgE mediated) & delayed (non-IgE mediated).

**Suspected food allergy**

### Immediate reactions (IgE mediated)

- Occur within 2 hours of contact or ingestion.
- Symptoms are consistent and reproducible and include rashes, itching, wheeze, GI symptoms, angioedema and anaphylaxis.

Skin prick tests (or blood tests for specific IgE antibodies to allergens/likely co-allergens) can help diagnosis.

### Delayed reactions (Non-IgE mediated)

- Occur >2hrs after ingestion, but within 2-3 days.
- Often difficult to reproduce and symptoms less specific. May present with eczema, colic, reflux, loose stools, constipation.
- No tests help diagnosis.

Treatment is 2-6 week trial of exclusion of the suspected food followed by reintroduction

**Referral is required when a child:**

- Has had an anaphylactic reaction.
- Had one or more severe delayed reactions.
- Has had acute allergic reaction with coexisting asthma.
- Has not responded to a single – allergen elimination diet.
- Moderate – severe eczema where cross reactive or multiple food allergies suspected.
- Has immediate or delayed allergic reactions to multiple allergens or food groups, especially if there is faltering growth.

**Or:**

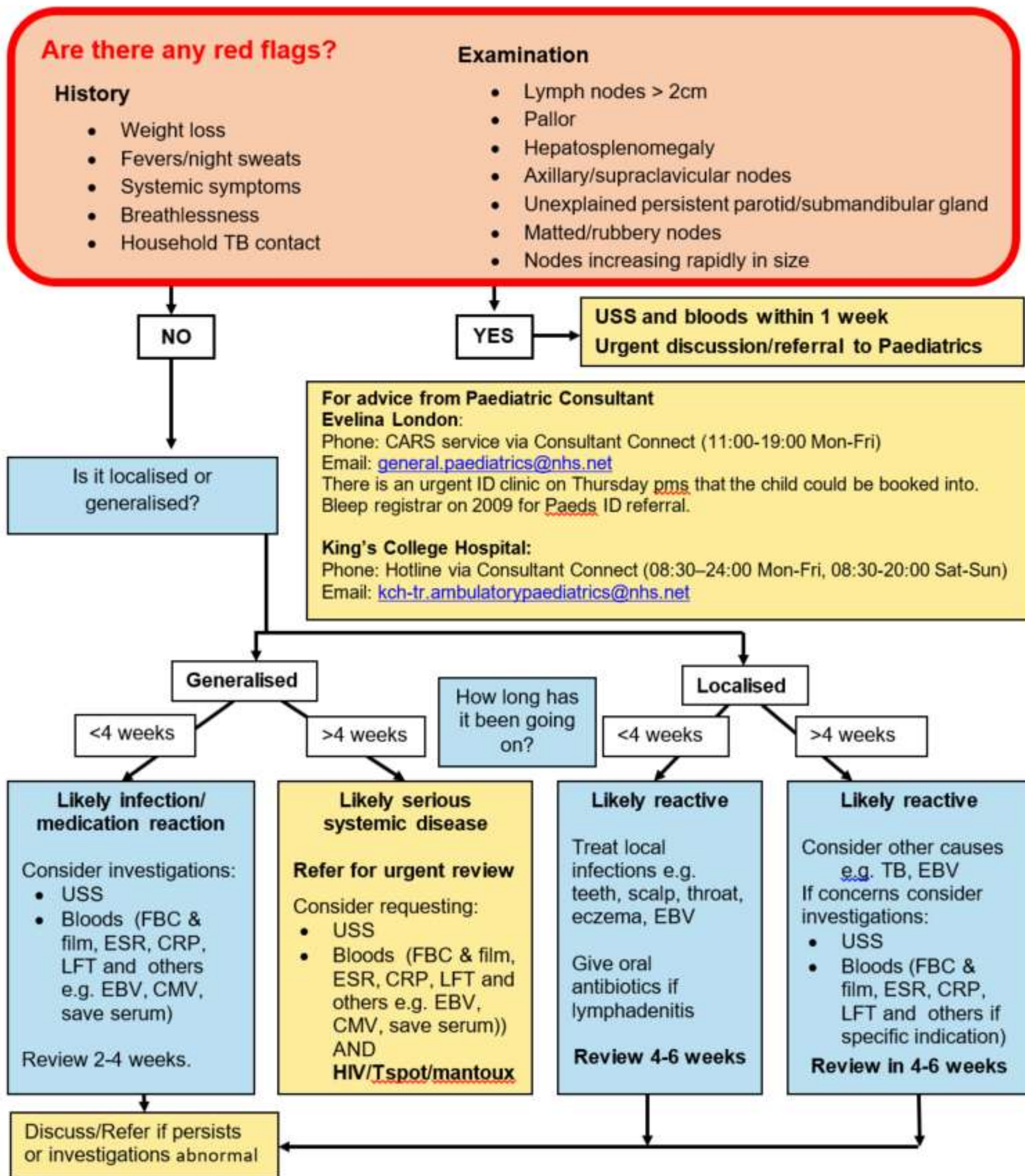
- There is a strong clinical suspicion of Ig-mediated food allerg, but allergy test results are negative.

## Top Tips

- All children who are excluding foods should be referred to a paediatric dietician.
- Most cases of urticaria lasting over several days are associated with a viral infection and do not represent a food allergy.
- Do not use serum-specific IgE testing to diagnose delayed food allergy.
- Children who have had anaphylaxis or who have food allergy and asthma should be prescribed adrenaline autoinjection devices.
- Families should be provided with training on how to use the device.
  Adrenaline autoinjection devices go out of date approximately every 12 months – check dates.
- Children who need adrenaline autoinjection devices should have two for school/nursery and two for home.
- Allergy UK: www.allergyuk.org/ has excellent advice sheets for families and clinicians.

**General Paediatrics**

# Management of Lymphadenopathy in Children




**TOP TIPS (Generalised)**

- Generalised lymphadenopathy is more worrying
- Most should have baseline bloods including LDH
- All should be reviewed

**TOP TIPS (Localised)**

- Most cases are reactive
- If systemic features present do FBC, ESR, CRP and film as minimum.

**General Paediatrics**

# Management of Urinary Tract Infections in children

Effective: July 2017
Review: July 2020

## Signs and symptoms

| Infants < 3 months | | > 3 months | |
|---|---|---|---|
| Fever | Lethargy | Fever | Frequency |
| Poor feeding | Haematuria | Abdo/loin pain | Dysuria |
| Vomiting | Irritability | Lethargy | Irritability |
| Offensive urine | Jaundice | Poor feeding | Haematuria |
| | | Vomiting | |

| Dipstick | Diagnosis | Action |
|---|---|---|
| Leuc +ve<br>Nitrite +ve | **UTI** – Start antibiotics | Send urine for culture |
| Leuc –ve<br>Nitrite +ve | **Likely UTI** – Start Abx | Send urine for culture |
| Leuc +ve<br>Nitrite –ve | **Unlikely UTI** - Only start Abx if high suspicion of UTI | Send for culture, may indicate infection elsewhere |
| Leuc –ve<br>Nitrite –ve | **Not UTI** – Not for Abx | Not for culture, look for alternative source of infection (except in infants < 3months) |

## Acute Treatment

**< 3 months**: Refer to paediatrics for IV abx
**> 3months with upper UTI:** 7-10 Days PO abx. Consider referral/ IV abx
**> 3months with lower UTI:** 3 days PO abx (reassess if still unwell at 48 hrs)

## Who to refer

**Acutely:**
Suspected UTI < 3 months
No response to Abx in 48 hrs
Abdominal mass
Septicaemia

**Routinely:**
Poor urine flow
Those requiring imaging (see below)

## Imaging

| <6 months | Abx response within 48hr | Atypical | Recurrent |
|---|---|---|---|
| USS acutely | No | Yes | Yes |
| USS within 6 weeks | Yes | No | No |
| DMSA (4-6 months) | No | Yes | Yes |
| MCUG | No | Yes | Yes |
| **6 months to 3 years** | **Abx response within 48hr** | **Atypical** | **Recurrent** |
| USS acutely | No | Yes | No |
| USS within 6 weeks | No | No | Yes |
| DMSA (4-6 months) | No | Yes | Yes |
| MCUG | No | No | No |
| **>3years** | **Abx response within 48hr** | **Atypical** | **Recurrent** |
| USS acutely | No | Yes | No |
| USS within 6 weeks | No | No | Yes |
| DMSA (4-6 months) | No | No | Yes |
| MCUG | No | No | No |

## Check for:

- Recurrent or atypical UTI (definitions below)
- Poor urine flow
- Antenatal renal abnormality
- Family Hx VUR (reflux)
- Constipation
- Dysfunctional voiding
- Large bladder
- Abdominal mass
- Hypertension
- Poor growth

## Atypical UTI

- Poor urine flow
- Septicaemia
- Raised creatinine
- Abdominal / bladder mass
- No response to antibiotics in 48 hrs
- Infection with non E-Coli organism

## Recurrent UTI

- 2 episodes pyelonephritis
- 1 pyelonephritis and 1 lower UTI
- 3 or more episodes lower UTI

## Top Tips

- Do not rule out UTI on the basis of dipstick alone in infants < 3months
- Obtain culture before starting abx
- Identify and treat underlying cause (CONSTIPATION)

**For advice from a Paediatric consultant:**

**Evelina London:**

Phone: CARS service via Consultant Connect (11:00-19:00 Mon-Fri)
Email: general.paediatrics@nhs.net

**King's College Hospital:**

Phone: Hotline via Consultant Connect (08:30–24:00 Mon-Fri, 08:30-20:00 Sat-Sun)
Email: kch-tr.ambulatorypaediatrics@nhs.net

**For routine referrals to general paediatrics:**

**Evelina London and King's College Hospital:** via ERS

The General Paediatric Guidelines were created in collaboration with:
Evelina London Children's Hospital
Children & Young People's Health Partnership
Variety Children's Hospital@King's