Child India

January 2024

Monthly e-Newsletter of Indian Academy of Pediatrics

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Editor's Note

Dear friends,

New year greetings to you all through the 1st issue of Child India for 2024.

On behalf of all of you we congratulate Dr Upendra Kinjawadekar and his team - HSG Dr Vineet Saxena, OB and EB 2023 for all the good work done and wish IAP President 2024, Dr Basavaraja GV and his team - HSG Dr Yogesh Parikh, OB and EB 2024 who, we are certain that under the able leadership of our energetic IAP President, will work in full earnest to ensure that the IAP flag flies high. We also congratulate Dr Vasant Khalatkar IAP President Elect and wish him the very best.

In 1984 the Government of India decided to celebrate the birthday of great Swami Vivekananda, i.e. 12 January, as National Youth Day every year. The philosophy of the Swamiji and the ideals for which he lived and worked is considered a great source of inspiration for the Indian youth. The day is dedicated to inspiring young minds, promoting education, and encouraging community service. The theme for National Youth Day 2024 is 'Arise, Awake, and Realise the Power You Hold'.

World Leprosy Day is celebrated on Jan 29th every year and the theme for 2024 is "Beat Leprosy". This theme encapsulates the dual objectives of the day: to eradicate the stigma associated with leprosy and to promote the dignity of people affected by the disease.

This issue, and a few to follow, with dwell on PICU topics as our IAP President, 2024 is an intensivist of repute. We are thankful to the contributors of the article on Pediatric Emergencies for this issue of Child India.

Happy reading,

Happy new year

Jai IAP!

Dr Jeeson C Unni
Editor-in-Chief

President's Address

Dear Pediatric Colleagues,

As we embark on a new year, I extend my warmest wishes for health and success to each one of you and your families.

In the current edition of Child India, we delve into a matter of paramount significance within the realm of pediatric health — "Pediatric Anemia: An In-depth Exploration." Beyond the precision of prescribing, managing anemia in children necessitates a nuanced understanding and effective communication with parents.

Anemia in pediatrics is a multifaceted concern that requires a comprehensive approach in its assessment and management. The challenge lies not just in prescribing iron supplements but in ensuring parents comprehend the importance of consistent medication administration and follow-ups. The varying formulations of iron supplements, such as ferrous sulfate and ferrous gluconate, demand clear communication to mitigate the risk of inadvertent errors in dosage.

Effective management of pediatric anemia goes beyond pharmacological interventions. It involves educating parents on dietary modifications, emphasizing the significance of regular blood tests to monitor progress, and addressing any concerns they may have. The journey to optimal iron levels in a child demands a collaborative effort between healthcare professionals and parents.

Within the framework of the IAP Action Plan 24, a commitment to releasing Good Practices guidelines is steadfast. In this edition, I'm pleased to note that our esteemed Senior SZ VP, Dr. Jeeson Unni, has provided valuable insights into the intricacies of anemia management in children.

I extend my sincere appreciation to the diligent Editorial team, led by Dr. Jeeson Unni, for their tireless efforts in crafting this informative periodical. Your engagement is crucial, and I eagerly anticipate your feedback and insights.

May your exploration of the intricacies of pediatric anemia in this edition prove enlightening and contribute to our collective pursuit of delivering the highest standards of care to our young patients.

Warm regards,

Dr. G V Basavaraja
Professor, Pediatrics and Critical Care
National IAP President, 2024

Secretary's Message

Respected Seniors and Dear Friends,

"Teamwork is the secret that makes common people achieve uncommon results."

January is the month of planning activities to be implemented in the year 2024. I am extremely happy to inform you that this month had a pleasant start with the Office Bearers Meeting held on 1st January 2024 at National IAP office. All Office Bearers were warmly welcomed at National IAP Office by the Hon. Secretary General, Dr Yogesh N Parikh. Allotment of all the 11 Action Plan modules was sent on the Day one - 01st January itself to the approx. 170 branches.

Also on the 08th, 09th and 10th of January 2024, we held a virtual meeting of the Executive Board for 2024. Various activities for the health and welfare of the child were discussed in this meeting, and some decisions have been taken in this regard. I thank all Office bearers and Executive Board members for their active participation and fruitful discussion in the best interest of child health.

As you all know, our Iconic 61st PEDICON 2024 was held from 24th to 28th January, 2024 at the Lulu Bolgatty Convention and Exhibition Centre in Kochi, Kerala, India. Health Secretary, Department of Health & Family Welfare, Govt of Kerala A.P.M. Mohammed Hanish inaugurated the conference. We are fortunate to have Hon. Justice of Kerala High Court Devan Ramachandran as a Chief guest, to grace the occasion with auspicious presence and guidance to the Pediatric fraternity. This event brought together Pediatricians, researchers, and healthcare professionals worldwide to discuss the latest advancements in pediatric care, research, and education. Over 7000 distinguished delegates graced the conference, including renowned Speakers and Editors. Our special thanks to Dr S S Kamath Chief organizing Chairperson, Dr M Narayanan Chief Organizing Secretary, Dr. M.I Junaid Rahman Organizing Treasurer along with Team Kochi PEDICON 2024 for meticulous planning and execution for making this conference a remarkable one in the history of Indian Academy of Pediatrics.

We have successfully conducted various meetings during IAP PEDICON 2024 at Kochi such as Physical Office Bearer meeting and Executive Board meeting on 22nd and 23rd

Secretary's Message

January respectively. Meeting with UNICEF on 25th January along with the meeting with Editorial board of Indian Pediatrics and Indian Journal of Practical Pediatrics, along with the Inauguration function. On 26th January meeting was conducted with office bearers of IAP Sub Specialty Chapter and Groups, office bearer of IAP Local/State Branches. Also the UG Quiz and Dr Shantilal Seth Oration was held on 26th January continued by the Annual General Body meeting. Office bearers meeting of Indian College of Pediatrics and National IAP took place on 27th January, followed by the PG Quiz and the Awards (Fellows of IAP, Hon. Fellow of IAP, Life Time Achievement, Social Champion, State & City Branches and Research paper - James Flett Awards, V Balgopal Raju Awards, ST Achar Awards, SS Manchanda Awards).

Along with this, Indian Academy of Pediatrics conducted 11 ToTs on the following modules under the Presidential Action Plan 2024. 1. Bridging from theory to Practice in Vaccinology 2. IAP FM 24-25, 3. OPSIS - Tiny to Tall, 4. Diagnostic Stewardship, 5. ABC OF Antibiotics, 6. GRID, 7. CODE Module, 8. RECIPE, 9. Gateway to Airway, 10. REAP and 11. ILEAF. We are thankful to Local Coordinators of these 11 ToTs for making ToTs a successful benchmark.

Regarding NC ECD, a total of 175 workshops of ECD have been conducted till date, including 1 workshop in the month of January 2024. Also, this month also witnessed successful conduction of total 22 Basic NRP and 9 Advanced NRP provider workshops.

On behalf of IAP, I urge you to organize various activities in the best interest of the health and welfare of the country's children. I humbly request all of you to motivate your friends, Colleagues and PG students to avail IAP membership as well as membership of IAP Family Benefit Scheme.

Long Live IAP, Jai IAP

In service of Academy,

Dr Yogesh N Parikh
Secretary General, IAP 2024 & 2025

President's Engagements

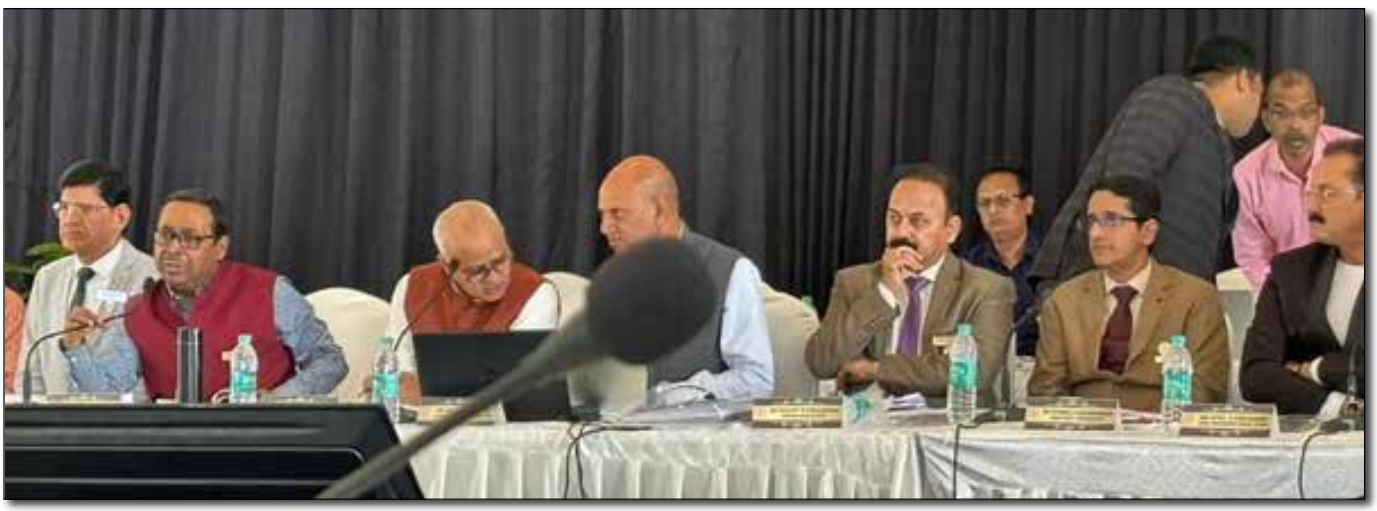
Exchange of Medallion and acceptance speech at PEDICON 2024, Jan 25th 2024

President's Engagements









2nd EB meeting conducted on 23rd January 2024 at Kochi

President's Engagements

2nd OB meeting conducted at Kochi on 22nd Jan 2024

President's Engagements

Welcoming National President during the First National Office Bearers meeting at IAP Office Mumbai

President's Engagements

National office bearers with National office staff at IAP Office Mumbai at 1st OB meeting

President's Engagements

**IAP National Executive Board members
at Bolgatty, Kochi on 25th January 2024**

President's Engagements

Welcome by Team Kochi

President's Engagements

Inaugurating Inter IAP State Cricket Tournament, PEDICON 2024, at St Paul's Ground, Kochi on Jan 24th

President's Engagements

At 6th meeting of India Expert Advisory Group on Measles and Rubella Jan 30, 31, New Delhi, with Dr Jacob John

President's Engagements

Pediatric Airway Emergencies & Pediatric Sepsis

DR MANINDER SINGH DHALIWAL
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Pediatric Neurology Emergencies

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Pediatric ingestion & poisoning

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Anaphylaxis

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Pediatric Airway Emergencies & Pediatric Sepsis

Pediatric emergencies are difficult to handle as they are time sensitive and need coordinated teamwork. The Pediatrician is usually the first point of contact for any of the medical or surgical emergency hence one needs to be well versed with early recognition and management of the common pediatric emergencies

In this article we outline the key emergencies that may be encountered and the basic steps of management. To handle any emergency in children certain generic skills are required that needs to be second nature in all health care professionals to get the best possible outcome

- Early Recognition
- Initiate appropriate management
- Call for and work as a team
- Appropriate skills to be acquired, maintained and enhanced
- Always ensure safety of the child
- Effective communication with team mates and the family

Pediatric Respiratory Emergencies

Acute respiratory distress and failure is the commonest medical emergency in children especially young infants (1). Young children are innately prone to respiratory failure due to their high O2 demand along with multiple factors related to their anatomy including narrow airways, less cartilaginous so easily collapsible, bulky soft tissues and difficult upper airway anatomy with higher resistance, highly compliant chest wall, low functional residual capacity, easily fatigable muscles. As we know that airway resistance is inversely proportional to the fourth power of the airway radius. In other words, even small mucosal edema or secretions can exponentially increase the airway resistance in younger children making them work very hard and prone to respiratory failure. The high metabolic and O2 demand and the unfavourable respiratory mechanics make young children prone to respiratory compromise early hence swift recognition and corrective steps need to be taken.

The first step is to take a history and recognise the red flags towards distress such as fast breathing, irritability or drowsiness, noisy breathing, inability to sleep/feed and excessive cough. Key signs to recognise include respiratory rate both tachypnea and bradypnea. Air being equally distributed or not in all lung fields. Any adventitious sounds like stridor [suggesting upper airway pathology], wheeze [suggesting lower airway pathology] or crepitations [suggesting alveolar or parenchymal pathology] and grunting [suggestive of lung parenchymal pathology with distress] Recognition of use of accessory muscles starting from nasal flaring, intercostal subcostal or lastly suprasternal is important to know the severity of the condition. Difficulty or talking or taking feeds is also a marker of severity. The effects of hypoxia in the form of irritability or late stages drowsiness and the signs of hypercapnia again by drowsiness is paramount to recognise as respiratory failure is setting in.

The management of a child with severe respiratory distress should follow the standard sequential ABC approach.

Stridor: Hoarse inspiratory sound generated usually from the upper airways. The most common cause of stridor in children is viral croup (acute viral laryngotracheobronchitis). Less common causes include non-infectious (spasmodic) croup and an upper airway foreign body (AFB). Rarer causes of stridor in the absence of trauma or burns include tonsillitis, anaphylaxis, tracheitis, diphtheria and epiglottitis (2).

Croup: Croup is a common respiratory tract infection usually viral in nature called Acute Laryngotracheal bronchitis, occurs in less than 3 years above 6 months age group. It affects about 6 % o the children yearly. A short history of fever and coryza precedes the classic barking cough indicating croup. 95 % of the children need only outpatient treatment. Only severe ones needs admission and management as below.

Severe Croup is an airway emergency hence handle with care !

- Keep child on parent lap as comfortable as possible.
- Avoid interventions that may annoy the child. However place O2 that is tolerated and keep on continuous monitoring
- First line start nebulised Adrenaline. This acts immediately within half hour however effects wane by 2 hours. [7] A dose of 0.5 ml/kg (1 of 1:1000) adrenaline up to a maximum of 5 ml and this may be repeated.
- Oral or IV steroids are effective and reduce symptoms within 6 hours lasting up to 12 hours. Oral /IV dexamethasone (0.6 mg/kg) or prednisolone (1 mg/kg) is recommended (3).

Airway Foreign Body [AFB]

A potentially dangerous problem and a very common occurrence especially in less than 3 years old children is an AFB. The history of choking is usually present in a witnessed event. History of difficulty breathing, noisy breathing -stridor or wheeze is also present. The above glottis or upper airway FB's may present with stridor or voice alteration. If unrecognised AFB's may lead to fever, distress and wet cough. Localised decreased air entry , localised wheeze or a persistent pneumonia are pointers. If the child is stable then the FB is usually immobile and probably lower down. Fluctuating signs and symptoms, intermittent stridor may be a sign of a mobile FB and it can be life threatening. The history of choking preceding the symptoms is the most sensitive and specific indicator of an airway FB. Hence always ASK for this specific history. The definitive treatment for the AFB is removal by bronchoscopy [rigid or Flexible] . The child should be immediately transferred to a centre having this facility and always accompanied by a doctor during transport as this is an impending respiratory failure due to airway complete obstruction. Asking for a retrieval service may be needed when alone.

Epiglottitis: The inflammation of the Epiglottis usually by a bacterial cause resulting in painful upper airway obstruction in a toxic looking child is Epiglottitis. Thankfully with the universal introduction of the Haemophilus influenzae type-b (Hib) vaccination there has been a 10-fold reduction in epiglottitis presentations. This is a difficult airway and it needs to be urgently recognised and differentiated from the other causes of upper airway inflammation. Due to the supraglottic involvement there is painful swallow and drooling along with the glottic obstruction causing stridor. These children usually are toxic irritable prefer to sit and drool with dysphagia and stridor. As this is a critical airway the ENT and Anesthesia teams need to be alerted. Difficult airway management strategies involving skilled teams, preparation for a difficult intubation, surgical backup, careful inhalational induction preserving spontaneous ventilation and intubation using a tracheal tube one size smaller than usual. Antibiotic treatment with a third-generation cephalosporin, following swabs and blood cultures, is recommended (4)

Status Asthmaticus: is a medical emergency, an extreme asthma exacerbation characterized by respiratory failure with hypoxia and hypercarbia due to lower airway obstruction. The presentation of status asthmaticus in children is variable. The degree of wheeze is a poor correlate of the severity of asthma. A silent chest where no air entry is heard hence no wheeze is actually an impending respiratory arrest due to near complete lower airway obstruction. Other

evidence of may include restlessness, confusion, inability to speak, inability to lie down, pulsus paradoxus.

Steps of management include starting high flow O2 therapy immediately, Nebulised beta agonists continuous nebulisations with Oxygen, IV corticosteroids continue to be the mainstays of treatment for severe asthma. Intravenous magnesium sulphate has been shown to be effective in the emergency management. As asthma is primarily a disease involving expiration intubation and positive pressure ventilation forcing air into these airways may worsen the situation resulting in further air trapping, cardiovascular worsening of bronchospasm. In very severe cases where hypoxia doesn't get corrected or there is fatigue non invasive ventilation may be tried in expert hands (5).

Pediatric Sepsis

Sepsis is life threatening organ dysfunction caused by dysregulated host response to infection. A subset of sepsis with circulatory and cellular/ metabolic dysfunction is called septic shock and associated with higher mortality (6).

Sepsis in children remains the leading cause of mortality and morbidity despite standardised treatment guidelines, advanced organ support measures and universal immunisation. Severe sepsis accounts for about 4.5 million pediatric deaths annually accounting for > 8 % of all Pediatric Intensive Care Unit [PICU] admissions.

Briefly about latest in sepsis and septic shock in children:

Screening, diagnosis, and systematic management

1. Use blood lactate to identify high risk of shock
2. Use a protocol for management for sepsis related organ dysfunction.
3. Obtain blood culture before starting antibiotic therapy provided it doesn't delay the antibiotic initiation (7).

Antimicrobial therapy

1. Administer antibiotics within 1 h of recognition to children with septic shock and within 3 h of recognition in children with sepsis without shock.
2. Start with empiric broad-spectrum antibiotics to cover all likely pathogens.
3. Narrow the antimicrobial coverage after culture and susceptibility results.
4. Reassess daily for antimicrobial de-escalation.
5 The site of infection, etiological agent, clinical response and ability to obtain source control will determine the duration of antibiotics

Source control

1. Always search and obtain source control early. Wound debridement, drainage of pus, removal of infected plastics in the child etc.

Fluid therapy

1. Initial fluid bolus is 10-20ml/kg and reassess promptly for response

2. If PICU is available, administer up to 40–60 mL/kg in bolus fluids during the first hour and monitor for signs of fluid overload or intolerance.

3. If PICU is unavailable, avoid the bolus fluid and give only maintenance fluids. Administer bolus fluids only in the presence of hypotension, up to 40 mL/kg during the first hour and discontinue if signs of fluid overload or intolerance.

4. Balanced/buffered crystalloids are preferred for resuscitation rather than albumin or 0.9% saline, for the initial resuscitation. Starch and Gelatin are not to be used.

Hemodynamic monitoring

1. Target Mean Arterial Pressure [MAP] either between 5th to 50th or even > 50th percentile for age.

2. Bedside clinical signs should not be used in isolation to differentiate between warm and cold shock.

3. Use lactate trends, advanced hemodynamic monitoring along with clinical monitoring to guide resuscitation

Vasoactive medications

1. Epinephrine and Norepinephrine are the preferred vasoactive agents. Do not use Dopamine.

2. Either Epinephrine or Norepinephrine are the first line vasoactive agents based on clinical condition, local factors and physician preference.

3. Use the peripheral access initially to administer the vasoactive agents however ensure dilute concentration, if central venous access is not readily accessible.

Corticosteroids

1. Consider either IV hydrocortisone or no hydrocortisone in refractory shock (WR ?)

Nutrition

1. Early enteral nutrition is preferred to be initiated within 48 hours and gradually increased in a step wise manner

2. Vasoactive agents are not a contraindication for starting enteral nutrition.

3. Parenteral nutrition to be started only after the first week. (WR)

4. Routine Vitamin D Selenium Arginine Zinc Glutamine or Arsenic or thiamine supplementation is not necessary

Blood products

1. Transfuse Packed Red Cells only in unstable children when the Hb is < 7g/dl.

2. Likewise platelets and plasma need to be transfused only in bleeding children when indicated.

Immunoglobulins

1. Intravenous Immunoglobulin is indicated in toxic Shock Syndrome and not to be routinely used in severe sepsis.

Prophylaxis

I. Only high risk patients need stress ulcer prophylaxis not routinely in all sepsis patients

Pediatric Neurological Emergencies

Status epilepticus (SE) is the most common childhood neurological emergency. Any child who presents to a healthcare facility convulsing or having repeated seizures without regaining consciousness in between will be practically defined as SE. The International League Against Epilepsy (ILAE) defines SE in terms of time points (t1 and t2). They recommend initiation of treatment at t1, and if t2 is reached, that treatment should be escalated to prevent long term damage (8). The t1 is the time when a seizure is likely not to be self-limiting and is pre defined as 5 min in Generalized Tonic–Clonic (GTC) SE, 10 min in Focal SE with impaired awareness, and 10–15 min in Absence SE. Furthermore, they defined t2 to be 30 min for GTC SE and > 60 min for focal SE with impaired awareness. For other SE subtypes, including febrile seizure SE and focal SE with awareness, no duration has been proposed, leaving the older definition of >30 min.

Algorithms of GCSE Treatment in Individual Stages of GCSE

1. Phase zero (0–5 Min)

o Elevate head by 30 degree ;

- High flow O2 therapy with non rebreathing mask with reservoir
- Cardiac monitoring with continuous SpO2 and ECG monitoring (one lead), non-invasive blood pressure measurement
- Immediate Glucose check and correction of hypoglycemia intravenously
- Venous blood sampling for blood counts, serum electrolytes and blood gas
- Temperature control in case of fever or hyperthermia
- Monitoring of vital signs continues throughout GCSE therapy
- Simultaneous preparation for intubation and drugs should be on going
- At any time (not only in the first five minutes) during GCSE therapy, impaired oxygenation (desaturation, cyanosis) and/or ventilation (hypoventilation, apnea) should lead to the introduction of intubation, and ventilation

II. Phase 1 (>5 Min)

(Available benzodiazepines are diazepam (rectal, IV), midazolam (buccal, intramuscular (IM), intranasal (IN), IV), and lorazepam (IV, IN, buccal)

In pre-hospital setting a non intra venously administered benzodiazepine is preferred.

Rectal diazepam is usually given at a dose of 0.2–0.5 mg/kg (maximum single dose 10 mg, maximum two doses). Diazepam is lipophilic and rapidly penetrates the blood–brain barrier, leading to onset within a few minutes, a maximum effect after 10–20 min, and a long half-life of 20–100 hr.

Buccal midazolam is given at 0.2–0.5 mg/kg (maximum single dose 10 mg, maximum two doses) with a maximum effect expected after approximately 10 min and a shorter half-life than diazepam of 3–4 hr. Intra nasal midazolam (0.2 mg/kg/dose) is also proposed. At present, intra nasal midazolam is the best option for prolonged seizures >5 min in a pre-hospital setting.

Phase 2 (5-10min) : If an IV access has been obtained, IV lorazepam (0.1 mg/kg/dose, maximum single dose 4 mg, maximum two doses), IV diazepam (0.2–0.3 mg/kg/dose, maximum single dose 10 mg, maximum two doses), or IV midazolam (0.1 mg/kg/dose, maximum single dose 5 mg) should be considered. The effect of these drugs should be apparent rapidly, within 0.5–5 min.

There is insufficient evidence to favor either of these IV drugs with respect to seizure control. If the seizure does not terminate 5 min following initial benzodiazepine administration, then a second benzodiazepine dose should be administered. An application of more than two consecutive doses of benzodiazepines (including any dose given in the pre-hospital setting) increases the risk of respiratory depression and is associated with sedation. If no IV access is available, buccal and especially Intra muscular [IM] midazolam are also acceptable first-line anticonvulsants for convulsive SE treatment in the hospital setting.

Phase 3 (10-30 min)

IV Levetiracetam or IV Fosphenytoin; alternatively, Valproic acid IV or Phenobarbital can be used.

- Phenytoin: 20 mg/kg (max. 1.5 g/dose) at a rate of max. 50 mg/min (e.g., 1 g phenytoin in a 20-min infusion).
  - Risk of hypotension and/or bradycardia (use caution in patients with heart disease—in this case, consider another second-choice medicine)
  - Dilute in saline (Don't use Dextrose containing solution—this would precipitate phenytoin)

- Levetiracetam 40–60 mg per kg (max. 4.5 g) in a 15-min infusion
- Valproic acid 20 to 40 mg per kg (max. 3 g) in a 5 to 10-min infusion. Note: Do not give in severe hepatopathy and/or suspected mitochondrial disorders.
- Phenobarbital 15–20 mg/kg at a rate of max. 50 mg/min (e.g., 1 g phenobarbital in a 20-min infusion).

Phase 4 (>30 min)

- Refractory Status Epilepticus [RSE] occurring in about 30 % of children is when the 1st and 2nd line medications fail to abort SE. Here aggressive treatment at this point [t2] to avoid permanent neurological damage.
- The child at this stage needs to be in intensive care unit to receive further second-line drugs and/or general anesthetic drugs such as continuous infusion like thiopental, pentobarbital, midazolam, or propofol (third-line agents) with continuous EEG (cEEG) monitoring. Additionally, specific treatment for the underlining etiology should be started. There is yet no consensus on whether the end point of second line therapy is aborting the seizure or achieving burst suppression. Likewise it remains unclear how long a patient should be maintained in a pharmacologic coma. Expert opinion usually opts for 24–48 h of electrographic seizure control prior to a gradual withdrawal of continuous infusions. In a midazolam-induced coma, start with a loading dose of 0.2 mg/kg in a 2 mg/min infusion followed by an infusion at 0.05–2 mg/kg/h titrated as needed to achieve clinical and electrographic seizure suppression and/or EEG burst-suppression.

Pediatric Head Injury

Traumatic brain injury (TBI) represents another leading causes of death and disability in children between 1 and 18 years of age. TBI is typically classified as mild, moderate, or severe based on the Glasgow coma scale (GCS) (9).

Mild TBI- GCS 14-15

Moderate TBI- GCS 9-13

Severe TBI- GCS 8 or less

Infants are prone to falls with head injury because of their relatively large head and higher centre of gravity, their poor ambulatory skills and immature neck muscles. The Pediatrician should always keep in mind Non Accidental Injury [NAI] although uncommon but very important to recognise.

Imaging in head injury: In any TBI with altered sensorium a Plain / non contrast Computerised Tomography of the head and C spine is modality of choice. Several clinical decision guidelines have been validated and can be applied to determine which children with a normal or near-normal GCS can safely avoid CT. The PECARN algorithm, as outlined below, resulted in these recommendations for obtaining head CT in the pediatric patient after identifying children with a mild TBI (GCS 14-15) with a very low risk of clinically significant brain injuries (10).

Children <2 years:

- GCS ≤ 14 or palpable skull fracture or other signs of altered mental status: CT head recommended
- History of loss of consciousness for ≥5 seconds or severe mechanism of injury or occipital, parietal, or temporal scalp hematoma, or "not acting normally" per the parent or guardian: CT head vs. observation based on parental preference, age ≤ 3 months, worsening signs/symptoms in the emergency department, multiple vs. isolated findings, and physician experience.
- All others: CT head is not recommended

Children ≥ 2 years:

- GCS ≤ 14 or signs of basilar skull fracture or

other signs of altered mental status: CT head recommended

- History of loss of consciousness or severe headache or history or vomiting or history of a severe mechanism of injury: CT vs. observation (similar to above)
- All others: CT head not recommended

Treatment in head injuries:

- Opening the airway with cervical spine stabalization is indicated in children who cannot maintain an open airway or are unable to maintain adequate oxygen saturation with supplementary oxygen.
- Continuous cardiac monitoring recommended
- Intubation is recommended in a patient with a GCS of less than 9 due to the patient's inability to secure their airway.
- Hypotension at all times should be avoided and recognised early as negatively affects the outcome
- Isotonic crystalloids should be used to prevent and correct hypotension.
- Hyperventilation is recommended when there is impending herniation and not routinely. As this method is the fastest way to reduce the Intracranial Pressure [ICP] especially en route to the operating table.
- No evidence to use Corticosteroids.
- Hypertonic saline is the preferred hyperosmolar therapy agent to be used. Mannitol used in acute impending herniation. Bolus or continuous dosing of hypertonic saline may be used with the minimum dose needed to achieve and maintain ICP <20 mm Hg.

Common and Life-threatening Pediatric Ingestions

"One Pill Can Kill, especially in infants"

- Infants and young children in their pursuit of exploring the environment accidentally ingest dangerous substances causing potential harm. On the other hand adolescents or adults usually ingest the same with an intent of self harm or suicide.
- The situation is further complicated by the fact that these ingestions are often unwitnessed hence no accuracy on the quantity or type of ingested agent.
- Although the majority of household substances are harmless certain over the counter available medications or prescription medicines and few chemicals that can be accessible to the child can cause life threatening problems.
- Clinicians and pharmacists should be aware of common medications and medication classes that can potentially be fatal to children (weight less than 10 kg) with the ingestion of a single tablet/capsule or teaspoonful (11). Notable One-Pill-Can-Kill Medications/Classes are :
- β-Receptor antagonists • Benzonatate • Bupropion • Button batteries • Calcium channel antagonists • Camphor • Caustics • Clozapine • Diphenoxylate/atropine • Hydrocarbons
- Laundry pods • Methyl salicylate • Nicotine • Olanzapine • Opioids • Sulfonylureas
- Theophylline • Toxic alcoholism • Tricyclic antidepressants

General management strategies

- Get Authentic Advice- Call Poison Control Centres: In India, National Poisons Information Centre (NPIC), All India Institute of Medical Sciences (AIIMS), New Delhi-110029 is easily

accessible for both health care providers and the general public by internet (npicaiims2010@gmail.com) or telephone (011-2658 9391, 011-2659 3677) to provide consultation services regarding the management of an ingestion. Other poison centres in India are: Amrita Institute of Medical Sciences. Kochi +91-484-2858056 and CMC Vellore: 1800-425-1213.

- Supportive Care: Supportive care is the cornerstone in treating the patient with poisoning. Initial efforts both prehospital and in the emergency should focus on basic life support measures, including maintaining a patent airway with adequate oxygenation and normalization of vital signs including euglycemia.
- Ascertain the nature and time of poisoning.
- Do not induce vomiting
- Consider gastric emptying and administration of activated charcoal.
  - Gastric lavage is recommended in life-threatening poisoning that presents within one hour
  - It is contra-indicated if the airway cannot be protected or in the ingestion of hydrocarbons (risk of aspiration and chemical pneumonitis) and corrosives.
  - Multiple-dose activated charcoal (1g/kg every four hours) is used for substances with a long half-life (anticonvulsants, digoxin, and theophylline).
  - The complications of gastric lavage include aspiration pneumonia, hypoxia, mechanical injury to the gut and the induction of hypo-or hypernatraemia.
- Reduce the exposure by immediately removing all potentially contaminated clothing and wash the child with soap and water.
- Send samples for lab investigation (urea, electrolytes, blood glucose.) Urine and gastric aspirates should be saved for later toxicology analysis (where available).
- Drug levels to be sent where relevant (paracetamol and salicylate and others if available).
- ECG – important in cases of tricyclic antidepressants and unknown poisons. QRS prolongation is an early sign of cardiovascular involvement.
- Specific antidotes should be given as per instruction by Poison Centre.

Common poisons and treatment :

- Acids and alkalis: Corrosives: (Dish washers and toilet cleansers)

Management: No lavage and charcoal, pediatric gastroenterology opinion

- Hydrocarbons: (Kerosene, petrol, spirits, and lamp oil)

Management: No lavage, no charcoal, respiratory support, observe in emergency for 6 hours even if no symptoms

- Alcohols, perfumes and mouthwashes: (Methanol, isopropyl alcohol (hand rubs), and ethanol)

Management: No lavage, charcoal, and observe respiratory and renal system, specific antidote: Fomepizole

- Naphthalene: (Mothballs, deodorants, and dyes)

Management: Close monitoring for a week after exposure as features of toxicity may be

delayed, methemoglobinemia is managed as per protocol

- Bleach: Sodium hypochlorite (Household bleaching agents and disinfectants)

  Management is as for corrosive poisoning

- Eucalyptus oil: (antiseptics, and fragrances)

Management: Only symptomatic treatment is needed, anticipate seizures, monitor skin, gastrointestinal and respiratory system.

- Camphor (Rubs, perfumes, pain relief gels and oils, and inhalation capsules)

Management: Symptomatic treatment and benzodiazepines for seizures

- Rodenticide (phosphorus): (Inorganic phosphorus as yellow phosphorus and ratol, organic phosphorus as zinc or aluminum phosphide)

Management: Careful lavage with dilute potassium permanganate solution immediately after ingestion within 1 hour, followed by close monitoring and supportive therapy especially the hepatobiliary system, Vit K if PT INR prolonged.

- Pyrethroids: (Mosquito repellent solutions)

Management: supportive management and observation (12).

Prevention of childhood poisoning: Prevention of childhood poisoning is everyone's responsibility. Safe Placement of these harmful medications is out of sight not just out of reach. Use of child safe cabinets and containers, blister packaging and education is important.

Although majority of the pediatric poisonings are not severe recognising the life threatening ones is important so that appropriate early treatment can be instituted. Aggressive supportive care is vital.

Insect bites and anaphylaxis

Anaphylaxis is a medical emergency characterised by a life threatening form of hypersensitivity reaction that is defined as a rapidly evolving generalised multi system allergic reaction (13).

It is characterised by :

I. Sudden on set and rapid progression

II. Airway /Breathing /Circulation problems

III. Skin or mucosal changes like Angioedema, Urticaria, flushing. However in upto 20 % of children this may be absent

Diagnostic Criteria

Anaphylaxis is likely when 1 of 3 criteria are fulfilled:

(1) Acute onset of an illness (minutes to hours) with involvement of the skin, mucosal tissue, or both with either respiratory involvement or reduced blood pressure (BP)/ associated symptom of end-organ dysfunction; or

(2) >_2 of the following that occur rapidly after exposure to a likely allergen for the patient, including (i) involvement of skin-mucosal tissue, (ii) respiratory involvement, (iii) reduced blood pressure or associated symptoms, or (iv) gastrointestinal symptoms; or

(3) Reduced blood pressure as a result of exposure to a known allergen trigger.

Insect bite and anaphylaxis Hymenoptera venom allergy describes both anaphylactic and non-anaphylactic hypersensitivity to stings. Reaction types include sting-induced local or systemic allergic reactions. Local reactions last over 24 hours in which signs and symptoms are confined to tissues contiguous with the sting site. Systemic reactions involve generalized signs and

symptoms ranging from mild urticarial reactions to life threatening anaphylaxis (14).

Management:

Airway and Breathing:

- Clear and Maintain the airway
- Start high flow O2 supplementation with Non rebreathing mask with reservoir.
- If there is signs of critical obstruction like worsening stridor swelling of lips and voice change alert the senior airway specialist [Anesthetist/Intensivist] to secure the airway

Circulation:

- Immediate large bore IV access
- Start Isotonic Crystalloid bolus 10ml/ Kg aliquots due to the rapidly developing distributive shock that develops.
- Reassess and repeat boluses as needed

Medications:

- Adrenaline is the drug of choice.

Dose: 0.01 mg/kg of a 1:1000 [1 mg/mL] solution (maximum of 0.3 mg) in children

Route of administration: intramuscular at 5 min interval based on patient response

- Steroids – As they reduce the duration of illness.
- Antihistamines: H1-antihistamine helps to counter histamine-mediated vasodilation and bronchoconstriction.

Monitoring

Continuous Cardiac Monitoring and a period of 24 hours at least of observation as 20 % chances of recurrence.

Dosage Guide

Medication Name	< 6 months	6months to 6 years	6-12 years	Above 12 years
Inj ADRENALINE IM route	150 mcg 0.15 0f 1 in 1000	150 mcg 0.15 0f 1 in 1000	200 mcg 0.2 0f 1 in 1000	300 mcg 0.3 0f 1 in 1000
Inj Hydrocortisone IM or Slow IV	25 mg	50 mg	100mg	200 mg
Antihistamines Chlorpheniramine IM or Slow IV	250 mcg/Kg	2.5 mg	5 mg	10 mg

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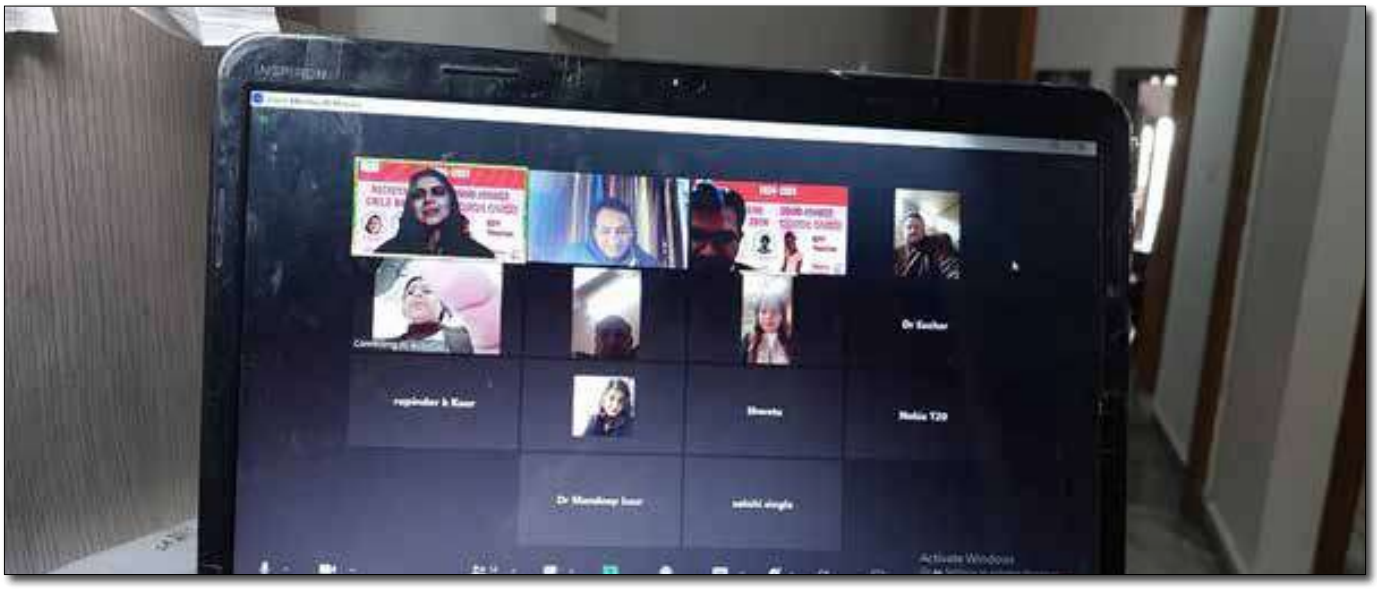
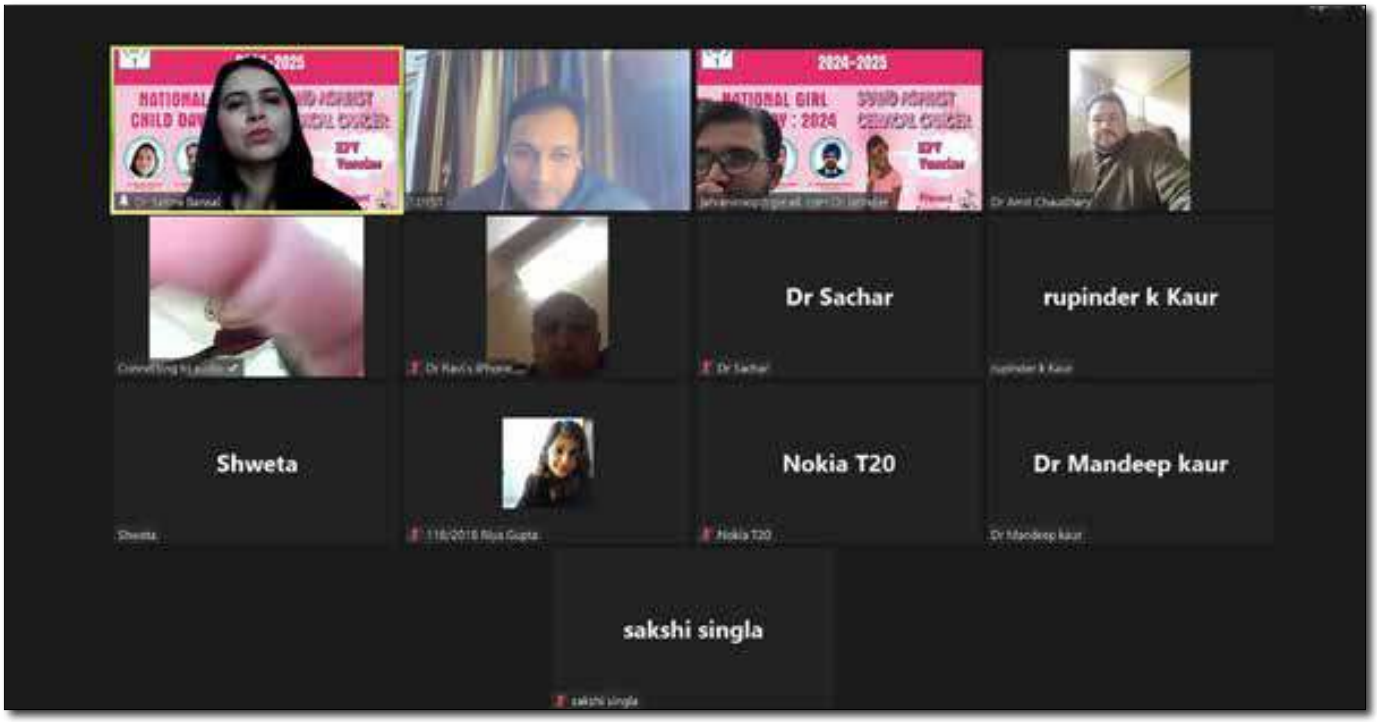
IAP Jalandhar

REPUBLIC DAY CELEBRATION ON 26 .01.24

IAP Jalandhar





HPV MODULE TRAINING - ONLINE WORKSHOP ON 28.01.24

IAP Jalandhar

NATIONAL GIRL CHILD DAY CELEBRATION

IAP Kerala

BLS TRAINING TO PUBLIC IAP KASARAGODE

DR TU SUKUMARAN ORATION BY DR GOWRISANKER AT STATE RESPICON CALICUT

IAP Kerala

PALLIATIVE CARE CME IAP TRIVANDRUM

IAP Kerala

HEMATOONCOLOGY CME IAP KANNUR

IAP Kerala

GREEN ARMY PROJECT IAP VADAKARA

2ND BATCH OF ESSENTIAL VACCINOLOGY COURSE IAP KERALA

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-INSTALLATION IAP THALASSERY

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INSTALLATION IAP KANNUR

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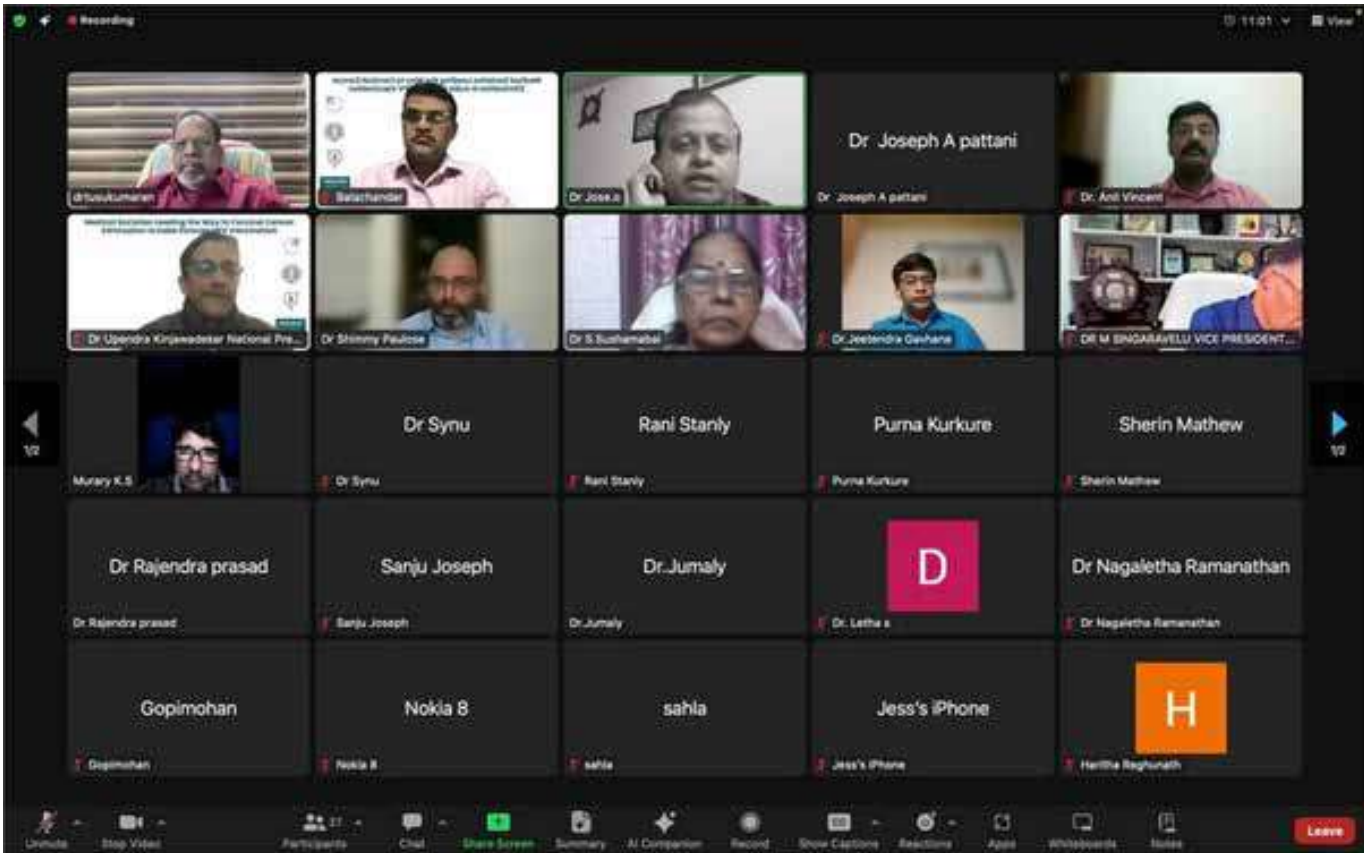


CIAP HPV VACCINE CME

BNRP PROGRAMME IAP PATHANAMTHITTA

IAP Kerala

PEDIATRIC SNIPPETS IAP KASARAGODE

NSSK PROGRAMME GMC IDUKKI

IAP Mumbai

Online Program - Lessons from the Masters

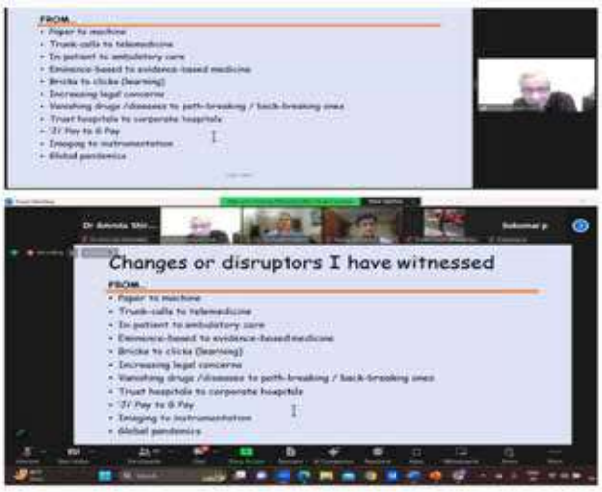
True teachers use themselves as bridges over which they invite their students to cross. Then, having facilitated their crossing joyfully collapse, encouraging them.. To create bridges of their own.

Dr Anand Shandilya, a great teacher and a wonderful human being was one such educator and mentor to many.

The **Anand Memorial Lecture** is organized every year in the loving memory of this legend on the **1st January**. This was the 5th year of his sad demise and the lecture was delivered on January 1,2024 at 9.00pm on an online platform.

Dr Raju Khubchandani was invited as the expert to deliver a talk for the "**Lessons from the Masters**." Sir gave a very introspective and an absolutely stunning talk on '**Midstreaming**.' The lecture gave an insight into the need to balance our professional, financial and personal lives in a perfect manner during our 60ties to live a very happy, satisfying life.

It was attended by 100 doctors on the zoom platform and many more on the you tube link who appreciated highly about Sirs very unique and fascinating manner to address a topic like the same.



IAP Mumbai

Newborn Hearing Screening Program

"Hearing Loss is a different kind of a silence..one that can be filled with frustration and loneliness". "Hearing Loss is a different kind of a silence..one that can be filled with frustration and loneliness".

Hearing loss has often been referred to as an **'invisible disability**.'There are about 4 - 5 per 1000 newborns detected with hearing impairment as per various data. **Hearing is the key for learning spoken language, performing academically and engaging socially**. Around 20 - 30 % of children with moderate to profound hearing loss can be missed till 3-4 years of age.

Universal NHS is taken up in only 40% of the medical colleges in India. Various constraints right from lack of awareness and initiative at the level of the caregiver and parents to limitations in existing infrastructure to execute the screening programs remains a major drawback in our country.

IAP Mumbai took its first small step to bring a change for this major disability by kickstarting it's **Newborn Hearing Screening Program** at the **Sir JJ group of hospitals**, **Mumbai.** In colloboration with **VConnect Foundation**, IAP Mumbai has committed to **Universal Screening** of all normal and high risk newborns for a period of **6 months** to begin with, commencing from **January 2, 2024**.

We express special thanks to Dr Bela Verma, HOD Pediatrics, Sir JJ group of hospitals to help us coordinate this program.

IAP Mumbai

Online session of CIAP ACS CFI HPV VACCINATION Module

HPV vaccination is much more than just prevention of cervical cancer. The gender neutral vaccine gives very effective protection against almost 6 types of cancers besides genital warts.

The first online session of **CIAP ACS CFI HPV VACCINATION Module** was held on the 9th Jan 2024 from 9.30 pm onwards.

It was attended by about **52 delegates.**

The meeting was honoured and initiated by a brief preview on the vaccine and it's implementation in routine immunization by **National Project Co ordinator, Dr Purna Kurkure and National Project Convenor, Dr Jeetendra Gawhane.**

The 2 modules of the CME were conducted by **Zonal Core Trainer,Dr Amin Kaba and Master Trainer, Dr Nehal Shah**.

Parent - doctor comunication scenarios were simulated by **Dr Amruta Shirodkar** and **Dr Jagruti Sanghvi** as a part of the module as a quick revision and understanding, thereby answering most of the queries.

IAP Mumbai

CME on Pediatric Sleep Disorders

A hearty laughter and a good sleep are the best cures for a healthy mental, physical and emotional health. Sleep Hygiene should be made an integral part of routine pediatric consultation to achieve optimal health.

Pediatric Allergy and Pulmonology Association in colloboration **with IAP Mumbai** organized it's very first **CME on Pediatric Sleep Disorders** on **14th January 2024** at **Sion Hospital** from **9.00am onwards**.

The expert faculty comprised of international faculty, **Dr Hemant Kulkarni along with Dr Sagar Warankar, Panel discussion by Dr Prakash Vaidya, Dr Samir Dalwai, Dr Kaustubh Mohite, Dr Parmarth Chandane, Dr Tripat Singh, Dr Mihir Shah, Dr Shridhar, Dr Lata Kasturi, Dr Indu Khosla and Dr Manisha Juvekar.**

Various insights from Ideal Sleep Patterns to all functional and organic issues involved with distorted sleep and their approach were delivered in an extremely clear manner.

The CME was attended by around **100 delegates** with active interaction.The CME was very well received by the audience and kept everyone wide awake!

Dr Harvinder Palaha was the local co ordinator for the program.

IAP Mumbai

Lecture at MM Pupils School

"Never let the fear of striking out, keep you from playing the game.."

Children often face this anxiety and pressure prior to their exams. A correct guidance may help them maintain the desired physical and mental balance.

IAP Mumbai took a small step in this endeavour to address and guide the young exam going teens to cope up with exam performance related issues by visiting **MM Pupils School** at Khar on the 17th January, 2024.

The session was conducted by Dr. Aditi Shah and Dr Shrunal Kamdar. It was attended by 33 students who are appearing for their 10th standard board exams this February.

It was a very informative and insightful session regarding focused attention, importance of sleep, adequate diet and hydration, screen exposure hygiene, posture correction and good revision skills.

A few techniques like **mind coolers, yoga and pranayams were taught by Dr Aditi Shah**. The students interacted and participated in the session thoroughly.

The entire workshop was coordinated by **Dr Shrunal Kamdar** and school coordinator **Mrs Dwisha Golatkar.**

IAP Mumbai

Advanced course on Neonatal Rescucitation Program

IAP Mumbai in collaboration with the P D Hinduja Hospital, Mahim organized the Advanced course on Neonatal Rescucitation Program in liason with iapnrpfgm/NRP at the Hinduja Hospital Auditorium on the 21st January 2024 from 8am to 5pm.

38 delegates participated in this program.

With **Dr Anjali Otiv** as the chief instructor and the faculty comprising of **Dr Sameer Sadawarte, Dr Minhaj Shaikh, Dr Neelesh Anand, Dr Prashant Dixit and Dr Viveka Singh.**

the session was very actively interactive and appreciated by the delegates.

Dr Soumya Renji was the Course Co ordinator for the session.

IAP Mumbai

National Girl Child Day Celebration

The **National Girl Child Day** is celebrated on the 24th of January each year to create awareness on their rights, their empowerment and their education along with supporting their aspirations, goals and self confidence.

IAP Mumbai organized a **CPR training program** for the women of **Kalpataru Aura Society**. It was attended by **35 enthusiastic** and dedicated participants including the female staff of the society and the gym trainers and security personnel.

The goal behind this activity was to create awareness about the need to be self competent to administer CPR in case of any emergency situation and share the happiness and satisfaction of having saved an individual's life in case of any emergency.

The event was organized by Dr Neha Nabar on behalf of Team IAP Mumbai.

IAP Mumbai

Mega Medical Camp

A **Mega Medical Camp** was arranged by the Dr Rajesh Pacharkar Foundation in the **tribal areas of Raigad district** on the **21st January, 2024.**

Around **550 residents** and **children of villages** underwent a medical check up by a team of expert Physicians, Pediatricians, Gynaecologists, Opthalmologists, Orthopedician, General Surgeon, ENT surgeons, Dentist and Physiotherapis.

ECG, Blood sugar levels, BP and SPO2 screenings were offered to indicated patients free of cost.

Calcium, Iron and vitamin supplements along with other symptom specific medicines were distributed to all of them and a fair stock of all the commonly used medicines was given for use in the Primary Health Centres. IAP Mumbai was happy to contribute the entire stock of medicines for the camp as requested.

IAP Navi Mumbai

NAVI MUMBAI IAP BRANCH REPORT JANUARY 2024

ACADEMIC –

1. 12th Jan 2024 – **Academics with Institutions**

   Host – Grant Medical College & Sir J J Group of Hospitals, Mumbai

   West Zone Co-ordinator – Dr Jeetendra Gavhane

   https://diapindia.org/event-details.php?event=2476&title=Academics-with-Institutions

2. 12th Jan 2024 – Apollo Health Care seminars – Gastroenterology & Hepatology

   Genomic perspectives of Hepato-Biliary Diseases

   Chairperson – Dr. Abha Nagral

   Moderator – Dr Snehal M

   https://us02web.zoom.us/j/88498435050

3. 14th Jan 2024 – **1st Pediatric Sleep CME**

   Pulmonology Association with IAP Mumbai

   Topic – **Sleep-disorders in children, Beyond Sleep Apnea**

   Expert – **Dr Sagar Warankar**

4. 24th – 28th Jan 2024 – 61st National Conference of Pediatrics, **PEDICON 2024**

   RHYTM Case Based Rheumatology Training Mission – Dr V Vishvanathan

   REAP Module (TOT) In-Vitro Allergy Test s – Dr Mangai S

   Neurodevelopmental Disorders & Autism Spectrum Disorders - Dr Leena Deshpande

   REAP Module (TOT) Skin Prick Test – Dr Vikram Patra

   Diagnostic Stewardship (TOT) – Chief Trainer Dr V N Yewale

   Panel Discussion – Allergen Immunotherapy newer insights & Talk on Child with Rhinosinusitis – Dr Vikram Patra

IAP Navi Mumbai

Talk on women empowerment in the world we are in – Dr Shilpa A

Panel Discussion – Bully Be Gone, Strategies for preventing & addressing bullying – Dr Amog Shahane

Routes of Immunotherapy – Dr Mangai S

Comprehensive Sex Education vs Abstinence – Dr Kalyani Patra

Hemoglobinopathies in children: Sickle Cell & Beyond – Dr Amit S

Panel Discussion: Fluid fundamentals, Optimal Management in critically ill child – Dr Satish Shahane

Panel Discussion: Congenital Conundrums: Infections in kids – Trends, dilemas, therapies. – Dr Jeetendra Gavhane

Consequences of pressure cooker environment for adolescents – critical thinking on killing fields of coaching centres in India. – Dr Upendra K

Role of Genetics in Nephrotic Syndrome – Dr P Moralwar

Emerging Fungal Infection s – Dr Dhanya D

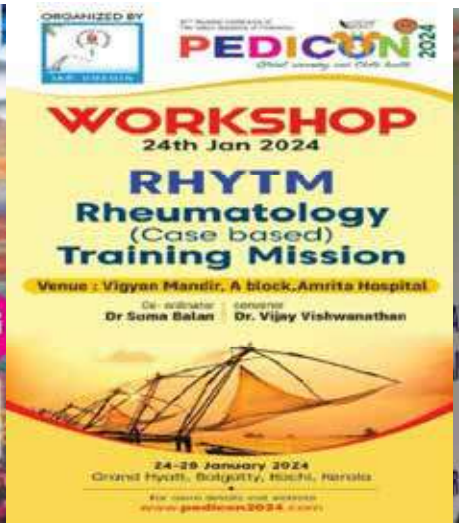
Panel Discussion: Painful emergencies, Setting Best practises for pediatric pain management – Dr Abhijit B

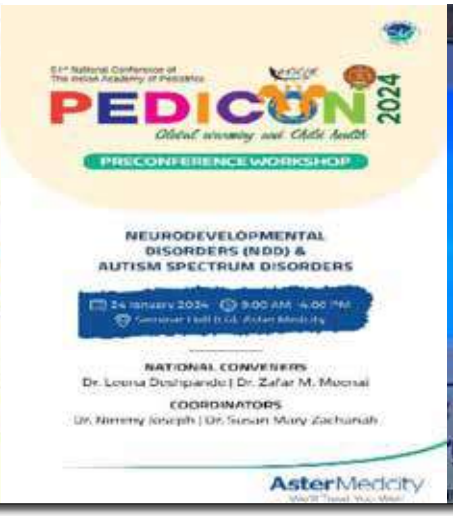
Talk on Rotaviral & JE Vaccine s -Dr V N Yewale

End TB by 2025! Where we are? - Dr V N Yewale

End Cervical Cancer Republic Day Parade – Organised by Dr Jeetendra G

IAP Navi Mumbai





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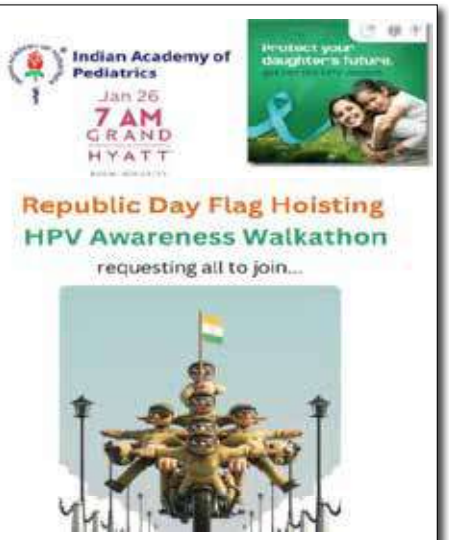

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