PAEDIATRIC ACUTE CARE GUIDELINE	
Baby – Common Presentations	
Scope (Staff):	All Emergency Department Clinicians
Scope (Area):	Emergency Department

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Baby – Common Presentations

- Parents regularly bring their newborn babies to the Emergency Department with all manner of complaints
- The ability to be able to identify those that have significant illness is a skill that you will learn throughout your paediatric training
- The challenge is to reassure parents that their concerns are valid but that their child is well and that there is no underlying pathology
- Below is a list of common presenting complaints and a lay-person explanation of the condition. If you have concerns about the diagnosis please discuss the patient with the Senior ED Doctor before speaking to the parent.
- This guideline should **not be printed and given to the parents**

Background

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Assessment

Differential diagnoses

'My baby is breathing very fast or seems to stop breathing'. There is no colour change.

Diagnosis: Periodic breathing

- Babies have an immature respiratory centre.
- When they breathe normally they blow off their CO_2 and this causes them to become hypocapnic and they stop breathing in response. This causes their CO_2 to increase and they then become tachypnoeic to blow off their increased CO_2 and they subsequently become hypocapnic and the cycle starts again…

'My baby's lips turn blue when he feeds'

Diagnosis: Peri-oral cyanosis

- There is a venous plexus below the top lip, and when the baby sucks this becomes engorged and is visable through the skin.
- The important things to ensure is that it is the area around the lips that turn blue and not the mucosa itself, and that the baby is feeding well, not sweating during feeds and growing.
- Concerning features:
    - Recessing, grunting, stridor or coughing especially after feeding
    - Tachypnoea with reduced feeding

'My baby hasn't opened his bowels for 5 days'

Diagnosis: Normal neonatal bowel function

- It is completely normal for babies to not open their bowels for up to 7 days at any one point. This is especially common in breast fed babies.
- Initially breast fed babies open their bowels regularly as colostrum is a stimulant laxative. This clears out the meconium and their stool changes to a yellow seedy consistency.
- Concerning features:
    - Meconium not passed in first 24-48 hours of life – these babies must be referred to the General Surgical Team

    - Excessive straining to pass stool
    - Blood passed with stool

'My baby vomits after every feed'

Diagnosis: Possetting

- All babies possett (bring up a small amount of milk after feeding)
- It is a normal mild form of gastro-oesophageal reflux – the muscle at the oesophageal-gastric entrance is weak and they are fed a liquid diet and spend most of the time lying down, they also swallow a lot of air whilst feeding and burping causes a small amount of milk to return.

Diagnosis: Over Feeding

- A full term healthy baby should feed (from Day 4) about 150 mls/kg/day divided into regular 2-4 hourly feeds
- It is vital that all babies you see have a calculated total daily intake of milk written as mls/kg/day
- For breast fed babies please document how often they are feeding and for how long and whether they are having bottle top-ups

Diagnosis: Gastro-Oesophageal Reflux

- As explained above all babies reflux to some degree
- There are 2 concerning types of reflux that result in poor weight gain and therefore require treatment and/or further investigation:
    - Painful reflux:
        - Acid is refluxed into the oesophagus and the baby screams during feeds and refuses feeds
        - This type of reflux responds well to acid supression e.g. Ranitidine, Omeprazole, Lansoprasole
    - Excessive vomiting:
        - It is important to recognise that there is no definitive treatment for this type of reflux
        - The only cure is a Nissen fundoplication which is used in children with profound reflux causing regular aspiration pneumonia
        - The first step in treating this type of reflux is positioning. During feeding and for at least 30 mins after feeding the baby should be kept as upright as possible.
        - Regular winding during feeds can also help
        - If this does not work feed thickeners can be used – mixed with water and given via a syringe for breast fed babies or added to the formula milk
        - Babies that are vomiting so much that they are not gaining weight should be

referred to the General Paediatric Team for further investigation
    - Parents should be advised that most babies will grow out of this condition once solids are introduced

Concerning features in vomiting babies:

- Fever and vomiting
- Projectile non-bilious vomiting in a hungry baby
- Bilious vomiting
- Vomiting in a baby who looks unwell
- Weight loss or failure to regain birth weight

'There's a lump sticking out of my baby's belly button'

Diagnosis: Umbilical Hernia

- A weakness in the abdominal muscles around the umbilical cord is extremely common
- It will appear larger when the baby cries because as they inflate their lungs the abdominal contents get pushed down and out
- It is not causing them pain
- They do not obstruct and therefore do not need surgical repair
- Most will have disappeared by 1 year of age but some remain for longer
- Consider General Surgical Team referral in children over 1 year of age with a large umbilical hernia

Diagnosis: Umbilical Granuloma

- Fibrous tissue at the umbilicus
- It used to be (and sometimes still is) removed using a silver nitrate stick but this practise has been stopped as significant burns were occurring to the surrounding tissue
- They will resolve and do not need any treatment
- If parents are adamant they want it removed make sure you surround the granuloma with Vaseline to prevent contact burns

'My baby has blood in his wee'

Diagnosis: Urate Crystals

- Excretion of calcium and urate in the urine can be visable as orange-red staining in the nappy
- It is extremely common in the first few days but can be a sign of significant dehydration later on

'My baby is bleeding from her vagina'

Diagnosis: Hormonal withdrawal

- This is a completely benign and common condition that causes great stress for parents
- It is related to maternal hormone withdrawal and only lasts a few days
- Concerning features:
    - Vaginal bleeding outside the neonatal period

'My baby boy has boobs'

Diagnosis: Maternal hormone response

- This can occur in both male and female neonates and is completely benign and self-resolving
- Concerning features:
    - Breast enlargement outside the neonatal period
    - Unilateral swelling
    - Signs of infection: hot red swelling, pus formation

'My baby is producing breast milk'

Diagnosis: Maternal hormone response – 'Witches milk'

- As above, this is a completely benign, if somewhat alarming, condition which occurs in neonates as a result of maternal hormonal surges

'My baby is moving funny, are they fitting?'

Diagnosis: Moro Reflex – 'Startle response'

- Normal response to noise, sudden movement or touch
- The reflex is present from birth and disappears at 4-6 months
- Concerning features:
    - Tonic-clonic movements
    - Unilateral movements
    - Associated colour change

'My baby isn't gaining weight'

- Understanding weight loss and gain in the neonatal period is vital
- Your assessment of any infant should include plotting their weight and head circumference on an appropriate growth chart

Day 1	Birth weight
First week of life	Weight loss – up to 10% of the birth weight is acceptable
Day 10-14	Baby should have regained their birth weight

- Further weight gain can be remembered by the old adage "*an ounce (30g) a day except on Sundays*"
  i.e. a healthy baby should gain approximately 120g per week

Average Weight (50th Centile)	
Birth	3.5 kg
6 weeks	4 kg
Six months	7 kg
1 year	10 kg

'My baby has spots'

Diagnosis: Erythema Toxicum Neonatorum

- The most common pustular eruption in newborns
- Aetiology is unknown
- Usually appear day 2-3 and fade by day 7, although they may recur for several weeks
- Fluctuating generalised eruption
- No treatment is needed

Diagnosis: Milia

- Caused by retention of keratin within the dermis
- Occur mainly on the face but can occur anywhere
- Usually disappear within the first month
- No treatment is needed

Diagnosis: Neonatal Acne

- Stimulation of sebaceous glands by maternal or infant androgens
- Usually resolves by 4 months of age
- Treatment not usually recommended but refer to Dermatology Team if extensive

Diagnosis: Seborrheic Dermatitis

- Also known as “cradle cap”
- Can affect any area
- Occurs within 1st month
- Self resolves within a few months
- Emollients and shampoos are available and soft brushing can help remove scales
- Persistent seborrheic dermatitis may require ketoconazole – please discuss with the Emergency Department Senior Doctor before prescribing

Tags

apnoea, babies, baby, bilious, blue lips, bowel, breathing, Common, convulsion, crying, dermatitis, feeding, fever projectile, fit, fitting, ftt, gor, gord, granuloma, grunting, hernia, hungry, infant, irritability, non-bilious, possetting, Presentations, rash, reflux, screaming, seizure, spots, umbilical, unsettled, unwell weight loss, vomiting, vomits, young infant problems

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