A Few Pointers for Judicious Pediatric Practice

We intend to point-out and emphasize some current recommendations for managing common clinical scenarios.

Fever uncontrolled by paracetamol is a common and disturbing issue to many parents. Current evidence does not show any significant benefit from sponging which on the contrary may cause discomfort to the child [1]. Similarly, simple febrile convulsions do not require routine administration of anticonvulsants. Cough remedies in the form of variously concocted antitussives and mucolytics are no better than placebo in children with acute cough, let alone the risk of adverse effects [2]. With reference to childhood asthma, multiple lineages of evidence suggest that oral salbutamol is ineffective in its treatment and use of the same is associated with increased risk of adverse effects compared to the inhaled dosage forms [3]. Probiotics are now a debatable modality of treatment of acute infectious diarrhea of childhood. Efficacy studies showing evidence regarding strain-related benefit is mostly from the developed countries, and extrapolation of these results to our settings where normal gut-colonization patterns are different, is bound to be faulty [4].

As for neonatal resuscitation, there is currently no role of routine oro-nasal suctioning of the newborn. It has now become mandatory to assess oxygenation during resuscitation by pulse oximetry instead of color. Persistent cyanosis in spite of a heart rate above 100 and/or labored breathing should always prompt delivery room continuous positive airway pressure. Further, in case of preterm infants, accumulating evidence suggests that there is no increased risk of necrotizing enterocolitis with early enteral feeding. Moreover, early feeding prevents cholestasis and sepsis and also shortens duration of hospital stay apart from bypassing the ill effects of parenteral nutrition [5].

These are examples of some of the scenarios which are often improperly managed or addressed in clinical practice. Whimsical implementation of diverse theoretical therapeutic alternatives that too with anecdotal or at times no evidence can only compromise the quality of care offered. We must not falter to deliver the most appropriate treatment to our patients at any cost.

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Partial Splenic Artery Embolization for the Management of Hypersplenism in Cirrhosis

A 10-year-old boy presented with extrapyramidal movements of 6 months duration. Wilson disease was confirmed by elevated 24 hours urinary copper excretion after Δ-penicillamine challenge. Ultrasonography of the abdomen revealed features of cirrhosis with portal hypertension. He had pancytopenia (Hemoglobin 9.1 g / dL, total leukocyte count 2×10^9/L and platelet count 45×10^9/L. Prothrombin time was elevated (20s, INR 1.6), but the liver enzymes were normal. Patient was started on trihexyphenidyl, Δ-penicillamine and zinc. For management of pancytopenia due to the hypersplenism, partial splenic artery embolization was done. The procedure was done under conscious sedation using coils through right femoral access. Post-procedure angiogram revealed partial occlusion of splenic artery, slowing of splenic circulation and patent gastro-epiploic artery. After 48 hrs, the patient developed post-embolization syndrome, characterized by fever and pancreatitis (abdominal pain along with serum amylase 214 U/L and lipase 895 U/L) which was managed symptomatically with analgesics, antibiotics and

intravenous fluids. The symptoms subsided over next three weeks. Ten days after the procedure, the total leukocyte count was $5.2x10^9$/L and platelet count was $135x10^9$/L.

Treatment of hypersplenism requires medical management of the primary disease. Splenectomy is associated with significant post-operative morbidity, increased risk of portal vein thrombosis, infections by encapsulated organisms and worsening hepatic encephalopathy when hypersplenism is due to cirrhosis. Partial splenic artery embolization (embolization of about 40-80% of the splenic tissue) is a better option as the risk of infections and worsening of liver function is reduced as some functioning splenic tissue is preserved. The rise in blood counts usually occurs within two weeks after the procedure. Post-embolization syndrome is the commonest complication encountered in more than 75% of the patients [1,2]. It begins after 24 to 48 hours and lasts for several days. It is self-limited and is managed conservatively. Other complications include pancreatitis, left sided pleural effusion, portal vein thrombosis and splenic abscess [3]. Mortality rate is around 0-6% [1].

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