The first three months – Surviving the baby clinic for GPs

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Notes

Challenges for new parents
1. Babies are being discharged from hospital after birth earlier than ever before and often before breast feeding has been established
2. The advice from health professionals is inconsistent
3. There is limited health visiting access depending on area and sometimes failure to communicate well with midwives post delivery
4. There is information overload for parents from the internet, books, family and friends
5. Sometimes there is not much common sense available – usually the mother’s instinct is right but you need to help her wade through the treacle.

Common problems presenting to GPs and paediatric clinics in the first three months are listed below.

Excessive crying and distress
- There is an excellent “15 minute consultation” paper written by Dr Sheila McKenzie on the subject of troublesome crying in infants (McKenzie 2013)
  o Crying is a means of communication between mother and baby till other means of communication have been established.
  o Babies may cry up to three hours a day up to three months of age – but that still seems like a lot.
  o Parents and professionals often attribute normal baby crying to medical causes and treat unnecessarily.
- Infantile Colic – ROME III defines this as episodes of irritability, fussing or crying that begin that begin and end for no apparent reason and last at least three hours a day, at least three times a week for at least a week

- Considerations in your assessment:
  o What has been tried so far?
  o What is the support structure for the mother – during the pregnancy and currently?
  o Remember that excessive crying is the commonest trigger for physical abuse so keep this in the back of your mind.
  o Is it the mother’s anxiety that needs addressing? mothers who have a history of anxiety are more likely to have babies who cry excessively (Petzoldt, Wittchen et al. 2014)

  Clues for an underlying medical problem include
  o Abnormal development or poor growth.
  o Abnormal neurology including NAI— stiff / floppy / irritable
  o Signs of an allergic disorder – see below ?(Koletzko, Niggemann et al. 2012)
  o Excessive or projectile vomiting
  o Persistent jaundice
• Signs of dehydration e.g. poor urine output
  • Distended abdomen

• In otherwise well babies general advice includes:
  • Environmental – calm soothing environment, don’t fuss, and gently rock if liked.
  • Light swaddling, hold close, don’t try and feed till calm, seek eye to eye contact when relaxed.
  • Continuity of advice – phone or in person – support till can cope
  • Not much evidence for the use of complementary treatments though studies are small. Many are tried and if they are not harmful then there is no problem with continuing e.g. fennel tea, cranial osteopathy, baby massage (Hunt and Ernst 2011). Avoid star anise
  • Not much evidence for probiotics. Infacol may help
  • The use of lactase is on the NHS choices advice and an option

Common feeding complaints
• Baby won’t latch / not getting enough / feeds too long or too short
  • Unless the. parent is really obviously going wrong with infant feeding I would leave to the expert lactation advisors but NICE has guidance on the basics to help you know if they are getting the right advice and to help you sound credible.
  • Are the expectations realistic? Babies will feed 8-12 times a day.
  • Babies feed differently – some are efficient, some take longer – be guided by their general wellbeing
  • Is the baby properly attached and is breast milk production stimulated?
  • Is the environment calm?
  • Enough skin/skin contact?
  • Is the mother getting some sleep / help etc.
  • Is the mother eating adequately? Is she being looked after?
  • Is the father keeping the guests away?

• Could there be an anatomical or medical problem?
  • As per crying baby
  • If there is coughing and spluttering during the feeds are you sure that there is no cleft involving the soft or hard palate or a TOF? These are rare but important to identify.
  • Does the baby really have a tongue tie? This is rarely functionally a problem but increasingly diagnosed. (Post, Daamen et al. 2012) and NICE. Robust evidence for efficacy is lacking but you may need to advise or pick up the pieces if the snip has not worked.

The vomiting baby:
• Posseting is normal – is the baby otherwise well and thriving? If so reassurance only is all that is needed
• Is the baby overfeeding if bottle fed?
• Is this Gastroesophageal disease (GORD) as opposed to gastroesophageal reflux? (Lightdale and Gremse 2013)
• Symptoms of GORD may include:
  • Feeding refusal
Excessive vomiting
Poor weight gain
Irritability
Sleep disturbance
Respiratory symptoms.

- Assessment and decision to treat is based on the history – some investigations in tertiary care when the diagnosis is in doubt
- Management of GORD includes:
  - "lifestyle changes"
    - Consideration of allergy as a cause – see below re management of diet
    - Feed thickeners – consider the calorie content or thickened milks if bottle fed.
    - Positioning – upright or prone (though prone not recommended in sleep)
  - Pharmacotherapeutic
    - Alginates - Gaviscon infant (Sodium Alginate, magnesium alginate) – watch sodium content. Not very evidence based
    - H2 antagonists – Ranitidine – beware theoretical risk of tachyphylaxis – stop working after 6 weeks
    - Proton pump inhibitors – Omeprazole – MUPS – dose needed unclear. Needs to be given 30 minutes before the feed.
- Consider raised intracranial pressure (OFC), bulging fontanelle, irritability
- Consider infection – urine, meningitis, other
- Consider a metabolic condition
- Red flags include bilious vomiting, abdominal distension, drowsiness, fever and irritability

Does the baby have an allergy?
Good references include: NICE guidance [http://www.nice.org.uk/guidance/CG116](http://www.nice.org.uk/guidance/CG116) and the MAP guidelines for primary care [http://cowsmilkallergyguidelines.co.uk/](http://cowsmilkallergyguidelines.co.uk/) where you can download the pathway. For further reading read the ESPGHAN guidelines (Koletzko, Niggemann et al. 2012)
- Symptoms may include:
  - Vomiting and pain, feeding problems with aversion
  - Eczema or atopic dermatitis
  - Loose mucousy stools, blood in the stools or constipation
  - Irritability, poor sleep
  - Faltering growth

- MAP (Milk allergy in primary care) guidelines
  - If breast feeding:
    - 2-4 week CMP exclusion diet
    - Mother to take 1,000mg Calcium and 10mcg/day vitamin D
    - Dietetic support
  - If bottle feeding
    - Extensively hydrolysed formula (plus maternal avoidance if mixed feeding)
  - If improves re-challenge after 2-4 weeks
If no improvement consider referral to an allergy clinic or paediatrician and an amino acid formula

- Tin of milk cost:
  - (Amino acid) Neocate LCP £28.30
  - (Extensively hydrolysed) Nutramigen £10.66
  - Aptamil pepti £9.54 (contains lactose) - not so good but tastes OK

**Babies who won’t sleep**
There is a great book on common paediatric sleep – normal and abnormal available (Mindell 2010). If you buy it you can download parental leaflets

- Normal sleep 0-2 months:
  - Total sleep 10-19 hours / 24 (average 13-14½). Bottle fed babies for longer
  - Awake for 1-2 hours at a time
  - Initially no diurnal pattern but eventually more sleep at night

- Common issues:
  - Day/ night reversal – keep things dim at night, get up in the am and expose to light
  - Irregular sleep patterns – should settle by 2-3 months
  - Active vs quiet sleep – during REM sleep (which babies have far more of) they will grimace, suck, snuffle, twitch and jerk – this is normal – if they wake, let them self soothe and go back to sleep unless they wake up properly
  - Environment – give the right advice on temperature, not co-sleeping, lying on back, type of crib etc.
  - Some babies sleep less – encourage the family to support the mother to nap when she can.

**Are the bowel motions normal?**

- Not opening bowels in the first two days of life is a red flag
- Abdominal distension is a red flag, especially if the baby is constipated - make sure that the anatomy is normal.
- Breast fed stools are highly variable – may be explosive
- A bit of blood and mucous in the stools is most commonly due to cow’s milk protein allergy but do ensure that the baby had vitamin K after birth. Acute intussusception in the first three months would be very rare.
- Green stools – not a worry if occasional and not unusual in breast-fed babies. This may just represent rapid transit through the bowel. Green stools being bad is often confused with green vomit that really is very bad an warrants immediate referral to a paediatric surgeon / paediatrician
- Infrequent stools – can be normal, can be allergy related, and not all straining is constipation. If the abdomen is not distended and the baby is growing well this is unlikely to be a worry.
Common rashes / colourings
- Erythema toxicum – can appear quite ‘juicy’ but think about staphylococcus which would need treatment with flucloxacillin. If the baby is very young or if there are any signs of sepsis (poor feeding, lethargy, fever) then refer to ED.
- Seborrheic dermatitis
  - Lots of emollients, steroid with an antifungal works well, appropriate shampoo if indicated
- Jaundice
  - Ensure not present in first 24 hours
  - Colour of stools important – pigmented? Pale stools is a red flag
  - Referral at 2-3 weeks to jaundice clinic
  - Be aware that we do still miss some infants with biliary atresia
- Jaundice
  - Establish perioral blueness which is common vs cyanosis. Check the oxygen saturations if you are not sure.

Stridor
- Congenital laryngeal stridor (Laryngomalacia) usually presents in the first couple of weeks of life and can get worse till 3-6 months of age after which time it resolves
- Mainly inspirational but can be present in expiration
- The voice is normal and it improves with sleep and is worse with crying and feeding
- Refer to paediatrics / ENT if there is significant respiratory distress or chronic inspiratory stridor to exclude a more serious anatomical cause e.g. haemangioma, vascular ring etc.

Lumps and bumps
- Umbilical granulomas – very common BUT
  - Be sure that they are what you think they are. They should be soft, moist, pink pedunculated, friable lesions of granulation tissue that vary in size.
  - Ask yourself if there is any chance that there can be a passage from the bladder (urachal anomaly) or bowel (omphalomesenteric anomaly) or if this could be an umbilical polyp which would not respond to cauterisation and which would warrant referral to a paediatric surgeon.
  - Treatment of umbilical granuloma includes cauterisation with silver nitrate (make sure you use lots of paraffin and don’t burn the baby), ligation or just leave alone.
  - Some advocate use of a potent steroid cream but risks may exceed benefits
- Hernias
  - Umbilical – rarely cause problems. Most completely resolve by 5 years of age so no need to refer unless you suspect a complication.
  - Inguinal – refer direct to paediatric surgery
• Hydrocoeles – Make sure that there is no associated inguinal hernia, reassure that should resolve by 2 years of age and refer to a paediatric urologist if they have not.

• Undescended testes – confirm (ask parent to check in a warm bath) then refer – operate by 1 year of age. Beware of congenital torsion of the testicle (small blue lump high in the scrotum) – this is rare but it is urgent to fix the other testicle in case there is an anatomical susceptibility for that one to tort too.

• Capillary haemangiomas (strawberry marks)
  o These will not generally be present at birth and will slowly increase in size till the first 6-12 months after which time they will slowly involute.
  o Worry and refer to paediatrics/ paediatric dermatology if:
    ▪ They are ‘central’ e.g. along the spine especially if lumbosacral or between the eyes.
    ▪ They are close to the eye or on the eye lid (may interfere with vision development
    ▪ They are in sensitive areas such as the nappy area or lips
    ▪ There are 5 or more lesions (ultrasound the liver) and consider if they may be in other sensitive areas – e.g. obstructing the trachea – in any case refer to a paediatric dermatologist or paediatrician.
    ▪ The lesion is very large (platelet trapping / cardiovascular compromise)
    ▪ There is associated apparent syndrome e.g. Phaces syndrome
  o Treatment with oral propranolol has revolutionised management

Sacral dimples
• No action if below the level of the natal cleft even if you can’t see the sinus - reassure

These are just a few of the common problems that we encounter in small babies in the first three months.

If you have any concerns and wanted to discuss with a senior paediatrician whilst you have the parents in the room with you or at other times, the attending consultant at UCLH holds a ‘hotline’ 07803853567 08.30-21.00 Monday – Sunday to give advice if needed. I am happy to be contacted too on c.petropoulos@nhs.net

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Weighing only 8.6 ounces at birth, the world's smallest baby ever to survive was able to go home earlier this month after spending five months at the Sharp Mary Birch Hospital for Women & Newborns in San Diego. The hospital announced her birth on Wednesday, and said the previous smallest baby was born in Germany in 2015, weighing seven grams more. Nicknamed Saybie by her medical team, the San Diego baby was born in December, just 23 weeks and three days into her mother's 40-week pregnancy. "Honestly, I feel bad for Sondland, because he was the first to testify," Noah said. "And he probably thought everyone else was gonna have his back and also say there was not quid pro quo, but then instead everyone snitched on him."