

# Children & Young Persons: Advice & Guidance templates

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# 1. Introduction

Many children are waiting too long for outpatient consultations with specialist teams. Historically, many appointments have been for conditions that are self-limiting or do not require specialist input. Outpatient care is at a turning point in terms of how technology can be used to enhance communication between primary and secondary care clinicians as well as families.

This guide provides advice and templates for a key aspect of outpatient services, Advice and Guidance (A&G) made available through the Electronic Referral System. A&G can play a key role in ensuring that children and families are supported most effectively.

A&G allows children's specialties to support GPs in providing optimum care closer to home. Key elements for success are the combination of advice that is consistent and incorporates best evidence, together with a response that is tailored to the individual child's presentation, circumstances and preferences. The templates provided in this guide provide a starting point for an evidence-based conversation between clinicians working in primary and secondary care, to support a child- and family-centred approach to delivering high quality care, whilst minimising unnecessary and inefficient outpatient activity.

GIRFT wishes to thank colleagues at The Royal College of Paediatrics and Child Health for working with us on this guide and sharing their expertise. We would also like to thank the general practitioners and paediatricians who have been generous with their time and expertise in creating these templates.

We hope you find this guide helpful. Please contact us with any suggestions of improvements by emailing [info@gettingitrightfirsttime.co.uk](mailto:info@gettingitrightfirsttime.co.uk)

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## Primary care perspective

Effective deployment of Advice and Guidance enables primary care colleagues to access quicker responses from specialists and provide more streamlined care for patients. Advice and Guidance is well established in the NHS. A 2022 RCGP survey found that most GPs already use Advice and Guidance and find it helpful. However, the same survey highlighted concerns that the timeliness and quality of responses could vary by the individual clinician, speciality and geographical area.

As contributors representing primary care, we actively shaped this guide, leveraging our insights as GPs to refine template responses. These templates aim to empower clinicians in elevating response quality and consistency, ultimately fostering improved patient outcomes. By enabling appropriate community-based management with specialist input, Advice and Guidance can reduce unnecessary delays, thereby contributing to an enhancement of patient care.

We hope this guide, alongside continued dialogue between clinicians, will help colleagues optimise Advice and Guidance to benefit patients.

**Graham Jackson**, GP Partner, Whitehill Surgery, Aylesbury. National Clinical Advisor, Elective Programmes, NHS England

**Oliver Morris**, GP, Shirley Health Partnership, Southampton and Wessex Healthier Together

## Statement from RCPCH

“This is a wonderful resource, co-produced by colleagues in primary and secondary care; this will help integration of care and ultimately help children and young people.”

**Professor Steve Turner**, President of Royal College of Paediatrics and Child Health (RCPCH)

## 2. The role of Advice and Guidance

Advice and Guidance (A&G), also known as Specialist Advice services, is an application within the NHS national eReferral system which supports asynchronous, bidirectional dialogue between primary and secondary care clinicians about individual patients.

A&G enables primary care clinicians to obtain clinical advice from specialists in secondary care, which means that patients can have a specialist management decision made at an earlier stage of their care. A&G can be used to support pre-referral dialogue or triage and plays a role in continuing professional development and education.

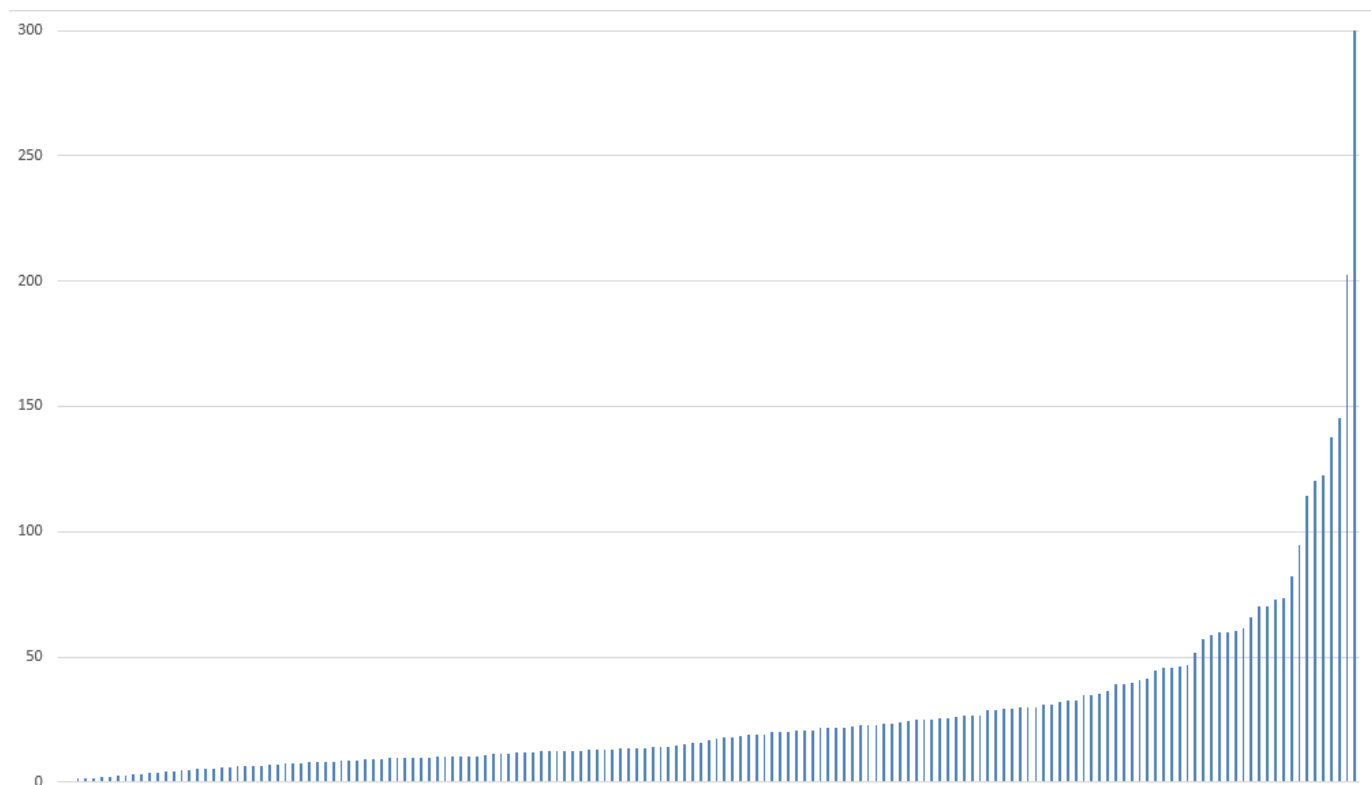
Use of A&G can help to reduce inequalities by ensuring that patients have access to specialist advice as early as possible. In areas where specialist advice is not used some patients are disadvantaged.

A key enabler for increasing the use of A&G is ensuring that both primary and secondary care services are adequately resourced to undertake this work.

The utilisation of A&G across England remains highly variable (see Figure 1 below), but during the COVID-19 pandemic it has become clear that systems which have adopted the use of specialty advice, in particular for pre-referral dialogue, have demonstrated greater resilience.

**This guide provides details on best practice for A&G responses as well as templates which clinicians can adapt and use for their local service. This supports providers to address national variation in practice.**

**Figure 1 A&G utilisation rate in general paediatrics across providers in England.**



*Source: Model Health System. Provider median of 15.2. Data from December 2023. Advice and Guidance utilisation rate is calculated using a numerator of the number of processed requests and denominator of outpatient first attendances. Where Trusts direct all referrals through Advice and Guidance this can lead to a rate of over 100.*

## Benefits

Effective A&G services should benefit patients, carers, primary care, and specialist services, as set out in the table below. Families save time and money by reducing the number of avoidable attendances at the Outpatient Department (OPD). There are also significant environmental benefits, as unnecessary journeys to and from hospitals account for a high proportion of the carbon footprint of these episodes as well as contributing to environmental air pollution.

Advantages to patients and carers	Advantages to primary care	Advantages to specialist services
<ul style="list-style-type: none"> <li>• More rapid access to specialist advice</li> <li>• Saved time from unnecessary attendances avoided</li> <li>• Reduced financial burden with regard to travel and or loss of income</li> <li>• Shorter waits for first OPD consultation</li> <li>• More care provided closer to home and/or in the community</li> <li>• Unnecessary OPD appointments of limited value are avoided</li> <li>• Access to 'straight-to-test' diagnostics</li> <li>• Fewer OPD visits needed to achieve diagnosis and treatment plan</li> <li>• Fewer patients find their appointments being rejected or redirected after booking</li> </ul>	<ul style="list-style-type: none"> <li>• Rapid access to specialist advice</li> <li>• Fewer repeat attendances in primary care by patients awaiting first OPD attendance</li> <li>• Ability to initiate further preventative or therapeutic measures in primary care</li> <li>• Clear understanding of when specialist review is required</li> <li>• Education resource to guide management of future patients with similar conditions</li> <li>• Reduced risk of rejection or redirection of a subsequent referral</li> <li>• Enhances the relationship between patients, families and primary care by maintaining continuity</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced unnecessary attendances in secondary care</li> <li>• As a consequence, balance the requirement for new patient OPD capacity</li> <li>• Shorten the waits for first OPD consultation, improving patient care and organisational operational performance</li> <li>• Allow the development of template-driven clinics, to provide more time for complex patients</li> <li>• Ability to easily triage patients to correct clinics</li> <li>• Only patients that require the service are seen by specialists</li> <li>• Ability to ensure patients pre-investigated where necessary to make an appropriate secondary care management decision</li> </ul>

## Medicolegal coverage and clinical responsibility

The expansion of A&G services has led to clinicians in both primary and secondary care seeking clarification on questions of clinical responsibility and medicolegal coverage. The NHS England Outpatient Recovery and Transformation team have developed two FAQ documents, summarised in Table 1, which seek to clarify the policy and support delivery of A&G services.

<b>Specialist advice and clinical responsibility FAQs &gt;</b>	<b>Medicolegal coverage and liability FAQs &gt;</b>
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Table 1 Summary of duty of care and responsibilities as described in medico-legal FAQ.

Situation	Duty of care (DoC) and responsibilities	
	Requesting Clinician (Requester)	Providing Clinician (Provider)
1. Patient presents at Requester	DoC engaged.	No DoC.
2. A&G request sent from Requester to Provider.	DoC continues. Take action if symptoms change or arise. Send sufficient information in request and mark urgency to assist triage process.	DoC engaged when in possession of referral for the symptoms referred or delegated. Trust to ensure referrals and requests triage is appropriate, timely, equitable and consistent.

3. Provider responds to Requester with advice. Not converted to referral.	DoC continues. Communicate to patient in timely manner. Act on advice within clinical competency. Ensure returned referrals are clinically indicated and in patients' best interests. (See situation 5 below)	DoC ends. Ensure referrals returned with advice are clinically indicated and in the patients' best interests based on information provided. Explain rationale and ensure advice is clinically appropriate for delivery by Requester. Provider is accountable if advice is clinically inappropriate or creates unnecessary delay in accepting referral which risks patient safety.
4. Response advises Requester to carry out diagnostic tests	DoC continues and re-engaged for previously delegated symptoms. If advice accepted: Request and review results of diagnostic test and act on them within scope of clinical competency. (See situation 5 below for responsibility when advice cannot be delivered)	No DoC. In advice, signpost Requester to use test results appropriately in ongoing management of the patient. Ensure any management advice is clinically appropriate for delivery by the requesting clinician.
5. Requester cannot deliver management or diagnostic advised.	DoC continues, ending for specific symptoms once delegated. Requester to respond to Provider in e-RS if advice is not in the patients' best interests, or if they cannot deliver management plan or investigations recommended by the specialist within the scope of their clinical competency.	DoC re-engaged when the Provider receives the re-referral.
6. Provider converts to referral or accepts referral	Management of patient while waiting based on interim advice. This does not include specialist management or undertaking specialist tests required for secondary care, unless by local agreement. Provide access for patient to communicate any deterioration in their condition.	Add patient to waiting list and inform patient. Provide sufficient interim advice for primary care management of patient while waiting. If Provider requires diagnostic tests, Provider must request and review results except where there is a local agreement, such as pre-existing pathway, to delegate investigations to Requester. Provide access for patient to communicate any deterioration in condition.
<b>Source of coverage</b>		
Request or respond to A&G within NHS Contract.	Covered by the Clinical Negligence Scheme for General Practice.	Covered by their employing trust's membership of the Clinical Negligence Scheme for Trusts, provided the Trust agrees they may Provide A&G as part of their NHS contract.
Activities and services not covered by NHS Contract	Maintain membership with a Medical Defence Organisation or other indemnity provider or insurer to retain cover for non-NHS or private work, inquests, regulatory and disciplinary proceedings, employment and contractual disputes and non-clinical liabilities.	



### 3. Tips for using the templates

- 1 Personalise responses to be specific and targeted to the patient and the query.
- 2 Be concise and highlight actions at the top, frontload the most important information.
- 3 Adapt the templates with any local processes or requirements, e.g. referral proformas.
- 4 Use polite and respectful language to ensure positive relationships are established and maintained with colleagues. Assume that the patient and family may see the response.
- 5 Provide a timely response and ensure there is an accessible record of the advice.

#### Suggested structure for advice and guidance responses

Function:	Example:
Opening	Dear [Dr ____], Advice and guidance response pertaining to [Patient name]
Suggested actions for primary care	This patient may be suitable to be managed in the community. You might try prescribing X for 6 weeks and reassessing.
Indications for re-referral	If symptoms persist, the patient should be referred for an assessment and consideration of appropriate surgical options. If the patient wishes to consider surgery, please re-refer.
Further information	The following patient information leaflets and decision aids may be helpful: [Links] The following NICE guideline sets out thresholds for surgical intervention: [Link]
Closing advice	If referring back, please state that the referral has already been through Advice and Guidance and include a copy of the previous correspondence, to ensure we don't duplicate advice. Please complete and send the urology referral pro-forma. With kind regards, [Clinician name and role]

#### Colour coding:

Grey	Standard information which doesn't usually change between responses.	Green	Suggested actions to be tried in primary care, adapt to be specific to the patient and query.
Blue	Adapt to provide sufficient information that is succinct.	Red	Indications for re-referral, for example, deterioration of symptoms, consideration of surgery. These may be specific to the patient or query.



## **Limitations imposed by computer systems in some trusts**

Different software is in use across Trusts to view and respond to A&G and sometimes this software limits the number of characters that can be entered in a response. You may need to use only the green and red sections of the templates, which are under 2,000 characters.

### **Suggested actions for primary care**

This section must be adapted to be specific to the patient and response, for example, removing investigations or treatments that are already completed or are not appropriate to the patient. The response may also depend on what diagnostic tests are available in primary care, or if there is a one-stop clinic set up.

Given the pressures on primary care, this section should be as concise as possible and should start with a clear statement about whether the patient could be managed in primary care or referred. Suggested actions should be short, even bulleted, and any additional detail or explanation moved down into the 'Further information' section below.

The response should give clear information to the requesting clinician explaining the rationale for suggesting management of the patient with specialist advice rather than conversion to a referral. The responding clinician is responsible for ensuring any management advice is clinically appropriate for delivery by the requesting clinician.

If the response recommends the requesting clinician carry out diagnostic tests, then the response include guidance to signpost the requesting clinician to use the results appropriately in the ongoing management of the patient.

### **Indications for re-referral**

The provider of A&G should highlight circumstances when a patient should be re-referred, for example if a patients symptoms deteriorate or if surgery is to be considered. This section will usually be consistent for a particular condition or pathway. It will need to be adapted depending on what clinics and services are offered at the Trust, in order to direct referrals to the correct clinic, and to include any steps required for referral.

### **Further information**

There is a balance to be struck between providing responses which are concise and responses which are educational.

The pressures on capacity in both primary and secondary care mean that a concise response will be quicker to write, read and action – both for the specialist providing the advice and also for colleagues in primary care receiving the advice.

However, A&G services often receive many requests for similar queries. Providing some further information and education in the response may avoid the need for specialist advice in future cases. This

may reduce the total volume of advice and guidance requests and therefore save time for both primary care and secondary care clinicians.

The appropriate balance between concision and education will vary by area, depending on how familiar clinicians working in a local health system are with advice and guidance. In areas where the use of advice and guidance is 'mature', for example where most clinicians have been using the system or have had equivalent communication channels for some time, it is likely that more concise responses may be preferred. In areas where there has been low utilisation of advice and guidance, or where there is less familiarity with which circumstances can benefit from specialist advice, it may be more helpful to include more information alongside the advice and guidance response to inform future requests.

## Closing advice

Clinicians have reported various examples of Trust specific processes and requirements which need to be communicated to their colleagues in primary care. These might include:

- **Enabling 'Convert to referral'**: Primary care providers and Trusts can enable an option where Advice and Guidance requests can be converted to referrals by the secondary care clinician. However, not every Trust or primary care provider has this option enabled, and clinicians may need to know to select it. In addition, even when this option is selected, some secondary care providers will still require a separate referral to be made to meet other requirements, such as providing referral information or confirming test results.
- **Referral proforma**: Some secondary care providers suggest a referral proforma to be submitted alongside a referral. In some systems it is possible to attach a proforma document, along with other supporting information such as scans and test results, alongside the Advice and Guidance request. In other systems, a referral will need to be submitted separately.
- **Duplication**: Some Trusts automatically treat all referrals as Advice and Guidance requests, and then use this to triage referrals. In this system it is important to flag the advice and guidance request if it has already been through the system, as otherwise it may receive a duplicate advice and guidance response rather than being treated as a re-referral.

## 4. Templates

### Quick links

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3. [Chronic cough](#)
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## 1. Abdominal pain

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to consider the following:

The most common treatable cause for abdominal pain in children is constipation:

- If the child is not passing soft, type 4 stools easily and painlessly, on a daily or alternate daily basis, then constipation is the most likely reason for the pain.
- It is important to ask the child themselves about their toileting as the parents often don't know the nature of their stools.
- Helpful parental information can be found here: <https://eric.org.uk/advice-for-children-with-constipation/>

Stress and anxiety are triggers and exacerbators of abdominal pain. Please direct to local resources for parents and families on mental wellbeing and managing stress.

A symptom diary can be helpful to quantify the symptom burden and identify potential triggers.

Investigations are of limited value in the absence of any concerning features, but if blood tests are considered then please ensure that coeliac screen is done (note that the child must be eating a gluten-containing diet for this to be reliable).

Faecal calprotectin or H pylori testing are rarely of any value and should not be performed routinely.

If red flag symptoms are identified, or the measures above are not helpful, a referral would be appropriate.

Please refer urgently if there are any of the following potential red flag symptoms:

- weight loss;
- melaena or fresh blood in stools;
- persistent diarrhoea; and/or
- child is being woken from sleep by pain and/or by the need to open their bowels.

Chronic abdominal pain is a common symptom in children and young people. Non-specific abdominal pain is the commonest cause, and is a benign condition: typically, this would present as periumbilical pain in a thriving child older than 3 years of age, and symptoms may often affect daily activities like schooling and play. Non-specific abdominal pain may be recurrent and/or persistent, and commonly can affect children intermittently for many months.

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 2. Capillary haemangioma

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

The mainstay of treatment in primary care will be reassuring parents.

Photography of lesions is helpful for monitoring.

Parents should be given safety net advice to return for review if meeting any of the referral criteria below.

A capillary haemangioma's surface is often dry and fragile, parents should avoid using bubble bath/soap on lesions and can apply a layer of petroleum jelly (e.g. Vaseline) twice daily to prevent drying out. Ulcerated lesions require referral (see below), but a non-adhesive dressing can be applied in the interim - however these will require close monitoring.

Patient Information: <https://www.bad.org.uk/pils/haemangioma-of-infancy/>

Refer (to either dermatology or plastic surgery according to your local pathway) if:

- large haemangioma (>5cms);
- ulceration (often occurs in nappy area or areas of friction);
- bleeding or infection; more common if ulcerated lesion;
- haemangiomas in a location with potential to cause functional impairment;
- close to or on eye – can cause visual impairment/impair development of orbit structures;
- nose or mouth – if any suggestion of impaired breathing or feeding;
- base of spine – can imply underlying spinal pathology;
- scalp – possible underlying cranial pathology if large/multiple;
- midline on neck – possible underlying laryngeal pathology;
- anogenital areas; or
- 5 or more haemangiomas may indicate internal lesions/underlying condition and requires further investigation.

A capillary haemangioma is a benign self-limiting overgrowth of blood vessels. They are common and affect up to 1 in 10 infants. Most occur on the face but can affect any part of the body internally or externally.

Capillary haemangiomas develop over the first few weeks of life. Usually, the most rapid growth is over the first 3 months. They may start as a pale spot with a red centre. Deeper lesions may appear blue/purple initially. They can continue to grow until approximately 12 months of age. Following this, capillary haemangiomas shrink and fade, this is often slow recession but usually complete by 5-7 years. They may disappear completely or leave a permanent mark.

Mostly they are asymptomatic and do not require treatment, but parents are often concerned during the rapid phase of growth.

Treatment is very rarely required and would only be commenced after secondary care review – this could include beta blockers or laser treatment/surgery.

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,  
[Responding clinician name and role]

### 3. Chronic cough

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to consider the following:

- Is this actually recurrent cough?
- Is this post viral cough?
- Is the cough wet?
- Are there other pathologies involved?

For persistent bacterial bronchitis (wet cough; possible previous temporary improvement with short course of antibiotics) - consider chest X-ray and treatment with a 2-week course of antibiotics according to your local guideline.

Refer for:

- persistent daily cough (>8 weeks duration) especially if worsening or wet;
- systemic features (such as weight loss; night sweats; persistent fever; clubbing);
- poor weight gain;
- haemoptysis;
- neonatal onset; or
- cough with feeding.

Recurrent cough

- The commonest cause of chronic cough lasting over 8 weeks (in a child who is thriving/well/no systemic signs or symptoms) remains recurrent viral infections, so ask "has your child coughed every single day, or has their cough got better and worse again?"
- Recurrent episodes of viral upper/lower respiratory infection can occur 7-10 times per year in school age children, often clustering in winter. No further investigation or referral is required unless there are concerns with growth/weight gain or systemic signs and symptoms.

Post viral cough

- In infants, post-bronchiolitic cough can persist for up to a month; and
- in school age children, cough associated with viral upper/lower respiratory tract infections mostly improve by 14 days (although it may sometimes take up to 8 weeks).

Other pathologies

- Early onset asthma (assess for triggers, atopic history, wheeze, shortness of breath);
- aspirated foreign body (suggestive history; persistent focal signs);
- post-nasal drip (history of atopy; nasal congestion);
- gastro-oesophageal reflux (suggestive history); or
- (rarely) serious pathology such as cystic fibrosis, tuberculosis or immune deficiency.

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 4. Constipation

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

Ask about non-medical factors – toilets and toileting behaviour.

- Is the child withholding?
- Are there emotional issues?
- Reward charts can help (important to only reward what is achievable, such as taking medication or sitting on the toilet)

Examination:

- examine abdomen;
- palpate for stool; and
- for early onset constipation - examine spine and neurology especially in legs.

Management should include:

- lifestyle measures – fluid and fibre intake AND treatment with laxatives.
- NICE Guidance suggests macrogols. Macrogols can be mixed with squash to make them more palatable but use whatever laxatives a child will take.
- If impacted, advise increasing doses of laxatives, and continue for 2 days after it appears the child has “cleared out” – when the child will probably have fluffy light loose stools, before reducing doses again. Clinicians should review after dis-impaction to check it has worked.

If red flags are identified, a referral would be appropriate.

Red flags for referral include:

- constipation from birth/neonatal period;
- failure/delay in passing meconium > 48hrs;
- ribbon stools;
- weakness in legs/locomotor delay;
- abdominal distension + /-vomiting;
- abnormal appearance of anus (do not do a PR);
- abnormal examination of spine;
- abnormal neuromuscular signs or reflexes; or
- persistent constipation not responding to maximal doses of laxatives.

Constipation is a very common problem in children and young people and is one of the commonest causes of chronic abdominal pain. Establish frequency of bowel openings and use Bristol Stool chart to characterise stool consistency – types 1 and 2 suggest constipation, but passing large stool which block the toilet is also characteristic. Diarrhoea can be a sign of overflow – soiling/diarrhoea with sticky tarry or smelly stool is characteristic of impaction/constipation with overflow. Pain in LIF also suggestive of constipation.

Let the family know that it is a chronic condition, there is no quick fix, and treatment may be needed for months – a good estimate is that a child will need laxatives for as long as they have been constipated for e.g. if constipated for a year, may need treatment for a year. Some children need laxatives even longer term. You can reassure parents that children do not get “reliant” on laxatives and there are no long-term side effects.

See ERIC guidance for constipation, including videos for children and families (<https://eric.org.uk/advice-for-children-with-constipation/>)

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 5. Eczema

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

The following are suggested treatment approaches from the British Association of Dermatology.

### 1. Treatment for eczema flare-ups (when skin is inflamed and itchy):

#### A. For children >12 months:

- Body, legs and arms: Mometasone or Betnovate 0.1% ointment (strong steroid) - apply once daily for 3-7 days and repeat as required. Avoid strong steroids on face and skin flexures, e.g. elbow and knee creases, armpits, groins and genitalia.
- Face and skin flexures (elbow and knee creases, armpits, groins and genitalia): Clobetasone Butyrate or Betnovate RD 0.025% ointment (medium steroid) - apply once daily for 3-5 days, and repeat as required.
- Continue steroid treatment for 2 days after the eczema has cleared.

#### B. For infants 0-12 months of age:

- Unless very severe, for infants less potent steroids should be used initially e.g. Clobetasone Butyrate 0.025% for body, legs & arms; 0.1% Hydrocortisone for face & flexures.

### 2. Maintenance management:

#### A. General skin care (ongoing):

- Regular emollient 2-3 times a day as required.
- Avoidance of soap/shampoo and use of soap substitutes.

#### B. Maintenance treatment to reduce flare-ups (for areas of skin which regularly flare):

Choose from:

- Tacrolimus ointment 0.03% (licenced for 2yrs to 15yrs) or 0.1% (16yrs or older) - steroid-free – apply twice daily until eczema controlled, then twice a week (face, flexures, body, limbs).
- Pimecrolimus cream 1% (licenced from 3 months of age) - steroid-free - apply twice daily until eczema controlled (face and neck).
- Mometasone ointment – apply twice a week (body and limbs).
- Clobetasone Butyrate ointment – apply twice a week (face and flexures).

Refer if:

- Eczema progresses despite above treatment plan or is severe and not responding to potent corticosteroids on the body – refer to dermatology through the Advice and Refer Teledermatology Service (A&G) and we will triage to an appropriate clinic appointment.
- Urgent/emergency department paediatric review if suspicion of systemic infection (especially suspicion of eczema herpeticum)

National Dermatology referral guidelines for Atopic eczema can be found here:

<https://www.bad.org.uk/referrals/atopic-eczema/>

Checklist if eczema does not improve:

- Is the correct strength and quantity of topical steroid being prescribed for the eczema severity? <https://cks.nice.org.uk/topics/eczema-atopic/prescribing-information/topical-corticosteroids/>
- Has a patient-measure of eczema severity been assessed? <https://www.nottingham.ac.uk/research/groups/cebd/documents/methodological-resources/poem/poem-for-self-or-proxy-completion.pdf>
- Does the parent understand how to apply the correct amount of topical steroid (including when the skin is broken)? <https://dermnetnz.org/topics/fingertip-unit>
- Are emollients being used correctly? <https://www.skinhealthinfo.org.uk/condition/emollient-use-in-skin-conditions/>



- Is the eczema infected? <https://cks.nice.org.uk/topics/eczema-atopic/background-information/complications/>
- Is twice weekly topical treatment being used to prevent flares?

#### Patient Information

- <https://www.skinhealthinfo.org.uk/condition/atopic-eczema/>
- <https://eczema.org/information-and-advice/treatments-for-eczema/>
- <https://www.eczemacareonline.org.uk>
- <https://bspad.co.uk/>

Child-specific management information (including advice of application of steroids):

<https://www.itchysneezywheezy.co.uk/Eczema.html>

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 6. Enuresis

Dear [Dr \_\_\_\_],

Advice and guidance response pertaining to [Patient name].

Examination:

- abdominal and genital examination; and
- neurological examination of the lower limbs and spine.

Management:

- Treat any constipation symptoms;
- Fluid intake - aim for 1.5L per day; avoid tea/coffee/squash/fizzy drinks; and avoid drinking 1-2 hrs before bedtime.
- Regular voiding during daytime and immediately before bed. Note - "lifting" to void overnight is not helpful long term.
- Reward charts may be helpful if age appropriate. It is important to only reward what is achievable such as drinking required volumes, taking medication or helping to change the bed (when they are old enough).
- Alarm treatment is the usual first line treatment.
- Consider a trial of desmopressin if alarm therapy is not tolerated/ineffective, as recommended in NICE guideline.
- If above management fails after 3-month trial period, consider referral to enuresis service (usually provided by community paediatrics or school nursing, see local guidelines)

Parental resources (e.g. advice, star charts etc) are available at [www.eric.org.uk](http://www.eric.org.uk)

Children presenting with the following red flags warrant a discussion/referral to general paediatrics:

- abnormal lower limb neurology – suggests spinal pathology;
- continuous wetting/dribbling – suggests bladder pathology;
- difficulty passing urine – suggests obstructive problem e.g. meatal obstruction;
- recurrent urinary tract infection;
- severe daytime symptoms; or
- safeguarding concerns (can rarely be a presenting symptom of abuse)

Nocturnal enuresis is common, affecting approximately 10% at 5yrs of age and 5% at age 10 years. There is often a history of enuresis in the family.

Primary enuresis (never been dry at night) is more likely to be physiological (deep sleep; small bladder capacity) but may rarely be associated with congenital/longstanding pathology (see red flags below).

Secondary enuresis (previously dry for >6months) is more likely to be associated with acquired pathology (e.g. constipation; recurrent urinary tract infection; physical effect of psychological distress).

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,  
[Responding clinician name and role]

## 7. Faltering growth

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

Health visitor (and/or breastfeeding professional) monitoring in the first instance, particularly:

- feeding patterns;
- latch/supply of breastmilk; and
- adequacy of feed volume (for formula-fed babies approximately 150-180mls/kg/day).

It is vital to have objective measures of trends in weight gain, usually obtained by health visitors – e.g. at least two measurements of weight and head circumference.

Infants >6 months and young children

- Health visitors actively involved in supporting families of infants and young children with faltering growth, including reviewing eating/feeding patterns.
- Objective measures of poor growth, usually obtained by health visitors i.e. at least two weight measurements for all children (and head circumference for <2yrs and height for >2yrs).
- Weight measurement interval: fortnightly for 6-12 months, monthly >1 year.
- Clinical assessment including development and psychosocial history.
- Recognise psychological impact of faltering growth on families and ensure adequate support.

Infants <6 months

- Thorough clinical examination
- Weight loss up to 10% of birthweight is common in the first few days.
- Concern arises if weight loss is >10% (or >12.5% in breastfed babies) or weight has not returned to birthweight by 3 weeks of life.
- Birthweight represents in-utero growth.
- An infant may move onto “their” centile after the initial period and may continue to grow along this. Provided that this trajectory represents good linear growth, this may be acceptable.
- Weight gain should be >180grams/week up to 6 months.

Reasons for referral

Urgent

- Infant who has not regained birthweight at 3 weeks of life.
- Infant with ongoing faltering growth despite maximal health visitor input on feed patterns/volumes
- Any rapid weight loss or concerns over undernutrition
- Safeguarding concerns

Routine

- Dysmorphic features
- Concerns over underlying chronic disease
- (>6 months of age) Unexplained short stature/ slow gain in height or length

Consider referral to dietitian instead if concerns over energy intake and/or eating behaviours are the primary concern(s) - dependent on ability to access timely local dietetic services.

Please include recent weight/height measurements in all referrals.

The commonest cause of poor infant weight gain is related to feeding issues. In the absence of indications for referral, health visitors (and breast-feeding professionals) should be the mainstay of assessment and support for most infants with faltering growth.

Infants should have at least two weight, length and OFC measurements to determine trajectory. Faltering growth is determined as:

- fall across 1 or more centile if birthweight <9th centile;
- fall across 2 or more centiles if birthweight between 9th & 91st centile;
- fall across 3 or more centiles if birthweight >91st centile;
- current weight is <2nd centile.

#### Helpful links

[https://www.piernetwork.org/uploads/4/7/8/1/47810883/faltering\\_growth.pdf](https://www.piernetwork.org/uploads/4/7/8/1/47810883/faltering_growth.pdf)

<https://www.nice.org.uk/guidance/ng75>

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 8. Foreskin

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

Prior to referral for children with phimosis (only required >10 years of age), a 6-week course of topical moderate steroid (e.g. fluocinolone) ointment twice daily to tip of foreskin is recommended.

In addition, a primary care decision tool may be helpful: <https://4skin-health.alderhey.nhs.uk/healthcare-professionals/>

Parents and children may also find the following resource helpful: <https://4skin-health.alderhey.nhs.uk/> .

Referral criteria:

Red flag:

Urinary retention (and examination findings of a palpable bladder).

Refer to paediatric urologist with any of the following:

- Evidence of penile lichen sclerosus (balanitis xerotica obliterans): a distinctive white plaque at the tip of the foreskin. Patients typically describe itching and increasing difficulty in micturition.
- Recurrent balanoposthitis (inflammation of the glans and/or prepuce) - although this is often self-limiting.
- Child older than 10 years with non-retractile prepuce.

It is common and normal for young boys to have a tight foreskin that is not retractile (phimosis).

The percentage of children with full retraction of the foreskin increases with age (by 17 years 99% are fully retractile: <https://ebi.aomrc.org.uk/interventions/list-3-draft/> )

Therefore, the principal treatment for children under the age of 10 years is reassurance.

Swellings on the penis are almost always smegmal retention cysts which spontaneously resolve when the foreskin becomes retractile.

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 9. GOR (Gastroesophageal reflux)

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

- Weight, length and examination should be performed.
- Remember: Certain symptoms of non-IgE-mediated Cows' milk allergy can mimic GORD – consider this in the differential diagnosis, especially in infants with atopic features.

Management:

- **If growth is adequate and child does not appear to be in pain or distress, then no further management is usually required.**
- Initially conservative – ensure not over-feeding (as a rule, more than 150ml/kg/day is excessive).
- Recommend small, frequent feeds; ensure upright after feeds; avoid frequent changes in formula.
- Health visitors should be actively supporting this.

If further treatment indicated:

- For breast-fed babies: Alginates (e.g. Infant Gaviscon: One half of dual sachet/feed, max 6/day) – mixed with cool boiled water or expressed breast milk and given on a spoon at start of feed. Advise parents that alginates may cause constipation.
- For bottle-fed babies: consider feed thickeners (refer to local formulary). If no improvement after 2 weeks, STOP and commence alginates (e.g. Infant Gaviscon) as above. (Avoid using thickeners and alginates together (or with commercial “anti-reflux” formula) as this can make feeds overly thick and lead to significant constipation).
- If no improvement after 2 weeks, seek advice from paediatrician via Advice & Guidance: a trial of proton pump inhibitor (e.g. omeprazole MUPS or lansoprazole orodispersible) may be recommended, although the evidence for efficacy is mixed (Omeprazole could be mixed into apple puree if tolerance is an issue).
- GOR usually improves with weaning, and most resolve by the first birthday. Treatment (with thickeners/alginates/PPI) can be discontinued based on symptom resolution, usually between 6-12 months of age – consider trial.

Referral criteria:

Urgent:

- bile-stained vomiting;
- persistent, projectile, non-bilious vomiting (would raise concern for pyloric stenosis)

Routine:

- no improvement after 4 weeks of medical treatment (with PPI);
- marked pain and distress;
- faltering growth;
- persistent respiratory symptoms;
- persistent symptoms beyond 1 year of age, despite ongoing medication.

Offer advice and reassurance to carers that GOR in well infants:

- is very common (affects at least 40% of infants);
- usually begins before the infant is 8 weeks old;
- may be frequent (5% of those affected have 6 or more episodes each day);
- usually becomes less frequent with time (resolves in 90% of affected infants before they are 1 year old) – brief explanation of reasons why can be helpful;
- does not usually require further investigations or treatment and treatment lacks evidence;
- acknowledgement of inconvenience, washing etc often helpful.

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 10. Headache

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

- A diary can be very helpful to identify triggers and tease out likely aetiology.
- In chronic headache also consider medication overuse headache.

Address lifestyle factors in all children with headaches, especially:

- ensuring they have had a normal optometric assessment;
- maintaining adequate hydration (recommended fluid intake 1-1.5l per day);
- minimising screen time;
- maximising sleep (duration and quality);
- reducing/addressing stress and anxiety triggers;
- clinical decision support is available if you are concerned about potential space occupying lesions  
HeadSmart - HeadSmart ([mybrainfirst.org](http://mybrainfirst.org)).

Migraine management:

- avoid triggers and address all lifestyle factors;
- Step 1 - use both paracetamol and NSAIDs together, consider trial of an antiemetic;
- Step 2 - if step 1 not effective, step up to a triptan +/- a simple analgesic (note triptans are not licenced for children below the age of 12 years; do not routinely start in children below 12 years without discussion with a paediatrician);
- Step 3 - consider a prophylactic medication >12 years if headaches occur twice a week or more, and/or significantly affecting daily activities or school attendance.

Red flags for urgent referrals include:

- aged <5 years;
- headaches worse in morning;
- headaches waking from sleep;
- persistent nausea +/- vomiting; or
- abnormal neurology.

- Headache is a common symptom both in school aged and adolescent children.
- Primary headaches are most common (e.g. migraine or tension headache).
- Tension headaches usually come on later in the day, and are associated with stress or tension – may be worse on school days, with exams coming up etc.
- Migraines can come on at any time and can often be very debilitating (children often have to stop what they are doing and go to bed). They are usually associated with nausea/vomiting/photophobia or visual disturbance and last hours to days. There is often a family history.
- Causes of secondary headache, which are much more uncommon, include headache secondary to eye strain, acute sinusitis or, rarely, space occupying lesion.
- In children with headache with normal neurological examination, the incidence of clinically significant brain abnormality on neuroimaging has been reported at between 0.4% - 1%. Among children with brain tumours, 98% have at least one neurological abnormality at the time of diagnosis, while 85% of children with brain tumours will have abnormal neurological findings within 8 weeks of headache onset.

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]



## 11. Head shape

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

Positional plagiocephaly does not require a referral. If parents have not yet accessed health visitor advice and support, they should be encouraged to do so, and can support ongoing management which is with:

- positional advice (changing baby's position when they are lying, encourage sitting up and "tummy time" when awake);
- ongoing monitoring of head circumference;
- physiotherapy may be helpful if there is sternocleidomastoid stiffness.

Refer if child is dysmorphic and/or developmentally delayed, or if head circumference increases by 2 centiles or more.

Refer to general paediatrics if cranial suture ridges are raised/palpable (and therefore concerns over synostosis); if there is developmental delay; or if head circumference increases by 2 centiles or more.

### Fontanelle closure

The posterior fontanelle usually closes by 6 to 8 weeks of life.

Closure of the anterior fontanelle is much more variable and usually occurs between the ages of 12 to 24 months.

Delayed closure may be associated with congenital conditions (e.g. hypothyroidism; Trisomy 21; mucopolysaccharidosis or skeletal dysplasia).

### Plagiocephaly in infants

Positional plagiocephaly (asymmetric flattening of the head on one side caused by pressure outside the skull before or after birth; PP) is the most common cause of asymmetric head shape in infants.

Typically in PP, the forehead will protrude further, and the ear sit more anteriorly, on the flattened side of the head compared to the other. When viewed from above, the head is the shape of a parallelogram.

Useful parental information and pictures of head shapes are here:

<https://www.nhs.uk/conditions/plagiocephaly-brachycephaly/>

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 12. Idiopathic urticaria

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

Recurrent episodes of urticaria without an identified allergen trigger, occurring for more than 6 weeks, are known as chronic urticaria. Chronic urticaria is usually idiopathic but can also be associated with influences such as heat, cold, pressure, or stress. A symptom diary can be helpful to identify symptom patterns and/or potential triggers.

There is no cure but antihistamines control symptoms. Second-generation antihistamines (cetirizine and loratadine) offer several advantages over classical H1 antihistamines (chlorphenamine), such as reduced sedation and impairment of performance, longer duration of action, and absence of anti-cholinergic side effects.

For intermittent symptoms give cetirizine/loratadine until flare-up has resolved.

Frequent symptoms (florid episodes that occur every week):

- Start on normal BNFC daily dose of cetirizine/loratadine for age.
- Dose can be increased stepwise to the lowest effective dose, up to four times the normal BNFC daily dose for age (note that this represents an unlicensed dosage but is in line with national guidance [https://www.bsaci.org/wp-content/uploads/2020/01/Urticaria\\_Angioedema2015-1.pdf](https://www.bsaci.org/wp-content/uploads/2020/01/Urticaria_Angioedema2015-1.pdf))
- The lowest effective dose may vary over time, so suggest parents trial dose reductions regularly. "Drug holidays" (short breaks from medications for 1-2 weeks) every six months are recommended.

Please refer to Paediatric Allergy Clinic if the following occur:

- Consistent trigger(s) identified causing immediate symptoms suggestive of IgE mediated allergy. Advise patient to avoid suspected trigger but if in doing so they continue to have the same symptoms it is not likely to be allergic in origin.
- Angio-oedema associated with breathing difficulties or airway obstruction.
- Physical urticaria symptoms (symptoms triggered by extremes of cold, heat or exercise).
- Recurrent angio-oedema without urticaria suggestive of hereditary angio-oedema.
- Chronic idiopathic urticaria and angio-oedema not well-controlled despite maximum daily dose of antihistamine.

Urticaria is very common and affects one in five people at some point in their lives. In most children, it is triggered by a viral infection, settles quickly and is no more than a mild inconvenience, but it can be severe, long-lasting and troublesome in some cases. Urticaria is often thought to be due to allergy, but in fact, allergy is not a common cause of urticaria.

Chronic urticaria lasts more than six weeks and affects 1 in 200 children. Individual spots last less than 24 hours and occur most days. Children with idiopathic urticaria often have dermatographism. Chronic urticaria is not associated with severe allergic reactions (anaphylaxis) and adrenaline autoinjector is not required. However, it can impact on quality of life by causing difficulty sleeping and problems concentrating at school.

Investigations (including skin prick testing, IgE etc) are usually unhelpful.

Chronic spontaneous urticaria often 'burns itself out': 40% of children will be disease-free after one year and 70% after four years. Treatment is directed at symptom control until the urticaria settles spontaneously.

Patient information: <https://www.allergyuk.org/wp-content/uploads/2022/09/CSU-leaflet.pdf>

BSACI guideline: [https://www.bsaci.org/wp-content/uploads/2020/01/Urticaria\\_Angioedema2015-1.pdf](https://www.bsaci.org/wp-content/uploads/2020/01/Urticaria_Angioedema2015-1.pdf)

If referring back, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 13. Persistent cervical lymphadenopathy

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

- In the absence of red flag features (see below), children who have lymph nodes which are small (<2cm in diameter), mobile and localised are likely to have simple reactive lymphadenopathy, which requires no routine investigations and are not a cause for concern.
- If they are tender and acutely enlarging then this is likely to represent lymphadenitis – treat with 7-10 days of oral antibiotics (refer to local guideline), with safety net advice to return for review if the nodes continue to enlarge, become fluctuant or the child is systemically unwell.

Please refer urgently for general paediatric review if any of the following potential red flag features are present:

- lymph nodes > 2cm or increasing rapidly in size (in absence of localised infection);
- axillary/supraclavicular nodes, or generalised lymphadenopathy;
- constitutional symptoms (e.g. weight loss, lethargy night sweats, persistent fever without focus);
- petechiae, or unexplained easy bruising;
- pallor;
- hepatosplenomegaly; or
- known family TB contact.

Palpable cervical (and sometimes inguinal) lymph nodes are very common in young children, and often persist for a long time.

If referring please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 14. Short stature

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

Children should have at least two weight and height measurements to determine trajectory. Parental heights (if available) can give an indication of child's expected genetic potential for target midparental height centile:  
{midparental height + 6.5cm} (male) or {midparental height – 6.5cm} (female) at twenty years of age). A current height centile which is within 2 centiles of the target height centile provides reassurance that they are currently growing in line with their expected genetic potential.

History should include:

- perinatal history including birthweight and maternal alcohol/smoking;
- nutritional intake;
- pubertal history;
- systemic symptoms (especially gastrointestinal symptoms, fevers, fatigue, headache);
- medication history; and
- family and social history.

A full clinical examination should be performed, to include assessment of dysmorphism and limb proportions; pubertal status where appropriate and focal neurological signs.

Investigations are usually not required, especially if growth appears appropriate for familial short stature, but if history and examination reveal any suspected underlying cause, then please refer with targeted appropriate investigations (including bone age in peri-pubescent children – a delayed bone age would point to constitutional delay)

Urgent referral for:

- history of significant or unexplained weight loss; and/or
- symptoms suggestive of intracranial pathology.

Routine referral for:

- height crossing two or more centiles;
- children with short stature who have not started puberty by age 14 years;
- evidence of dysmorphism;
- evidence suggestive of chronic illness (refer to appropriate specialty); and/or
- safeguarding concerns (refer according to local child protection pathways).

Seek advice and guidance for children who were born small for gestational age (intrauterine growth restriction) who have not demonstrated catch-up growth by 2-4yrs.

Short stature is defined as height that is below the second centile.

The most common causes of short stature are familial short stature and constitutional delay in growth and puberty.

Other important (but rarer) causes include:

- endocrine (hypothyroidism; growth hormone deficiency);
- syndromes (e.g. achondroplasia/hypochondroplasia; Russell-Silver syndrome; Turner's syndrome; Noonan's syndrome – these present with other associated features including dysmorphism);
- chronic illness (poor growth due to abnormally increased metabolic requirement) e.g. inflammatory bowel disease, coeliac disease, renal insufficiency, chronic infection, immunodeficiency);
- reduced calorific intake e.g. eating disorders; and/or
- neglect and safeguarding concerns.

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 15. Syncope or Loss of consciousness

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

- There is some evidence that iron supplementation helps with frequent attacks even if the child is not iron deficient.
- Menstrual history should be taken for all post-pubertal girls.
- Ask about family history (especially of sudden death).
- Management should be with lifestyle advice e.g. drinking well, eating breakfast, avoiding triggers.

Referral criteria:

Syncope during exercise or exertion is suspicious of a cardiac cause and should be referred to general paediatrics or paediatric cardiology.

Afebrile seizures should be referred to secondary care.

There are many non-pathological causes of loss of consciousness in children and young people.

Reflex anoxic seizures, or breath holding attacks are relatively common in toddlers and preschool children. The history will always include a trigger – fear, pain or anger e.g. crying. Children typically go limp/floppy, pale, and unresponsive. They may have a few jerks and then recover consciousness. They do not happen more frequently in the context of illness or fever and if the child is otherwise unwell, they should get the child assessed by a clinician.

Good advice can be found here:

Breath-holding in babies and children - NHS <https://www.nhs.uk/conditions/breath-holding-in-babies-and-children/>

Syncope (loss of consciousness) is a relatively common presentation in older children, although less common in younger children. There may be a trigger such as standing for long periods e.g. a lunch queue, not having slept well, missing breakfast etc. Young people will typically feel the episode coming on, they may describe a sensation of things going black. Occasionally they also have a few jerks.

If referring please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 16. TATT (Tired all the time)

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

History should focus on:

- age of onset, duration of symptoms and progression;
- preceding illness/infection;
- diet and eating, bowels and toileting;
- sleep – quality and quantity;
- mood;
- social history;
- effect on activities, school attendance and performance (if school-aged);
- a full clinical examination (including height and weight) should be performed;
- consider urine dip for glucose, first-line blood tests if indicated full blood count, renal function, liver function, thyroid function, coeliac screen, and serum ferritin;
- target other investigations based on specific symptoms (e.g. inflammatory markers if fevers/joints affected; faecal calprotectin if relevant gastrointestinal symptoms).

All children with ongoing symptoms for >3 months with no clear cause should be referred to general paediatrics.

Referral criteria:

- Signs or symptoms of proximal muscle weakness (e.g., difficulty climbing stairs or combing hair)
- Concerning associated symptoms such as weight loss, limb pain, other abnormal neurology, lymphadenopathy, fevers, hepatosplenomegaly, excessive bruising.
- Progressive, and/or moderate-to-severe symptoms not explained by history, examination or first line investigations as above.
- Any mental health or safeguarding concerns identified should be managed using the appropriate local pathway.

Low energy is a frequent presentation in children of all ages, with very different aetiologies. Differentiate from poor sleep, which tends to cause excessive sleepiness in daytime rather than low energy per se – although improving poor sleep may also help to improve low energy. Ask about snoring and signs of obstructive sleep apnoea

Common causes include:

- Post-viral recovery: particularly in young children who have had very symptomatic, or multiple serial viral infections, which may have affected their eating, and which takes some time to recover from.
- Anaemia – look for pallor. In younger children this may often be related to diet-related iron deficiency; in older girls consider whether menstruation-related.
- Low vitamin D: may sometimes cause fatigue and other nonspecific symptoms such as aches and pains.
- Low mood: may manifest as fatigue and lethargy. Ask about mood, enthusiasm for previously enjoyable activities, and possible reactive stressors.

Rarer causes include:

- Hypothyroidism;
- coeliac disease; and
- diabetes mellitus.

Malignancy is a rare but important cause of fatigue in children, although symptoms are usually more severe, progressive and associated with other symptoms (such as weight loss, fever, lymphadenopathy, excessive bruising, abnormal blood tests, limb pain, abnormal neurology).

If referring back, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 17. Tics

Dear [Dr \_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

- Please perform a full neurological examination on all children presenting with tics.
- In general tics do not require referral for specific general paediatric management.

Further information for families (including self-management advice and resources) can be found here: <https://www.what0-18.nhs.uk/parentscarers/worried-your-child-unwell/tics-and-tourettes-syndrome>

Suggested resource for families:

[https://www.tourettes-action.org.uk/storage/downloads/1374586646\\_Tic-tips---managing-your-TS.pdf](https://www.tourettes-action.org.uk/storage/downloads/1374586646_Tic-tips---managing-your-TS.pdf)

Please contact us (via Advice & Guidance in the first instance – please include a video if possible) in children where there is diagnostic uncertainty.

Please refer if:

- developmental regression;
- neurological abnormality on examination; or
- very severe or frequent symptoms interfering with normal daily activities.

If you have any concerns over serious associated mental health issues, please involve your local CAMHS team (via referral or self-referral, as per local processes)

Tics (sudden, rapid and repeated body movements or sounds that serve no purpose and are difficult or impossible to control) are very common in children aged 5 years and older (peak 10-13years). Tics commonly wax and wane and may change to affect different parts of the body over time. Parents can be reassured that the overwhelming majority will resolve without any medical intervention. Management is conservative and focused on reassurance, ignoring tics as much as possible, and reducing potential stressors/triggers.

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]



## 18. Umbilical hernia

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

Refer for routine paediatric surgery review for consideration of repair if still persistent at 4 years of age.

Note that the only indication for repair is to improve cosmetic appearance.

Although extremely rare, if there are any concerns about incarceration or strangulation (presenting with a hernia that is painful and/or irreducible, possibly associated with vomiting), please direct the child for emergency assessment in hospital.

Umbilical hernias present as soft reducible painless bulge in the umbilicus, formed as a result of incomplete closure of the umbilical ring after birth. They are often more prominent when the baby is straining/crying.

They are common (approximately 15-20% of population), and even more so among babies born prematurely and those of Afro-Caribbean ethnicity.

Unlike inguinal hernias, the risk of complications with umbilical hernias (e.g. strangulation or incarceration) is extremely small.

Most (even very large) umbilical hernias will resolve spontaneously by 4-5 years of age (90% by age 2 years).

Information for families: <https://www.nhs.uk/conditions/umbilical-hernia-repair/>

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,  
[Responding clinician name and role]

## 19. Undescended testes

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

Review babies at 6-8 week check to see if testes have descended;

Older boys who have had documented testicular descent as neonates will likely have retractile testes or secondary testicular ascent (both are less urgent). When examining, try to ensure that child is relaxed and not crying, and place left hand over both external rings prior to examining to prevent testes from retracting.

Boys with retractile testes of normal size that can be brought into the scrotum without tension do not require surgery.

Ultrasound has no place in assessment of undescended testes.

Indications for referral (to paediatric surgical service):

- babies with bilateral impalpable testes (urgent);
- babies with unilateral undescended testis at the 6-8 week check; or
- older infants and boys with acquired undescended testis.

Babies with bilateral undescended testes need urgent evaluation, most urgently to exclude congenital adrenal hyperplasia.

If testes have not descended by 3 months of age, they are unlikely to descend spontaneously. A 'watch and wait' policy after 3 months of age is therefore not recommended.

Surgery is recommended before 18 months of age to promote testicular development and future fertility.

Early referral optimises the chance of being able to achieve this.

Older boys presenting with undescended testes who have had documented scrotal testes likely have retractile testes or secondary testicular ascent. Around half of boys who undergo orchidopexy have secondary (acquired) testicular ascent.

The risk of testicular cancers is increased in intra-abdominal testes.

If referring please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 20. Wheeze

Dear [Dr \_\_\_\_\_],

Advice and guidance response pertaining to [Patient name].

You may wish to try the following:

Advise smoking cessation if parents/carers are smokers.

Primary wheeze can be treated acutely with salbutamol – ensure good inhaler and spacer technique.

Episodic wheeze rarely requires preventers unless episodes are very frequent or severe enough to require hospital admission.

If you suspect multi-trigger wheeze, it would be helpful to determine response to preventer treatment before specialist review. Please start an 8-week trial of inhaled corticosteroid (ICS) to establish a diagnosis using a moderate dose (e.g. clenil 100-200mcg twice a day). After 8 weeks, stop ICS treatment and continue to monitor the child's symptoms. If symptoms recur, restart the ICS and continue to monitor in primary care.

If symptoms did not resolve, review whether an alternative diagnosis is likely. Contact paediatric team for advice if required.

Please refer to paediatric team if any of the following are identified:

- Patient has required hospital admission for wheeze;
- faltering growth;
- clubbing;
- fixed chest crepitations; or
- wet cough persisting for 6 weeks or more.

If a child has been admitted to hospital with wheeze, their initial care should be led by a hospital paediatrician. Please refer them for paediatric review if this has not already happened.

Wheeze in children aged 1-5 years is very common. Most are primary wheeze – either viral-induced episodic wheeze, or multi-trigger wheeze (where the child may have interval symptoms as well, such as on exercise or at nighttime, and also commonly associated with atopy – please ask about family history).

If referring back, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]

## 5. Further resources

Recommended document	Author	Overview
<a href="#">Specialist Advice Services medicolegal coverage and liability Frequently Asked Questions</a>	NHS England Outpatient Recovery and Transformation Programme	FAQ document for clinicians, intended to be used as a signposting document to support conversations around legal liability and clinical cover for the delivery of Specialist Advice services.
<a href="#">Specialist Advice and Clinical Responsibility Frequently Asked Questions</a>		This document covers good clinical practice relating to SA, including delegation, clinical competency, diagnostic requests and turn-around times for reporting SA.

## 6. Contributors

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