



Urgent & Emergent Cases for the Office Pediatrician

Jay Pershad, MD

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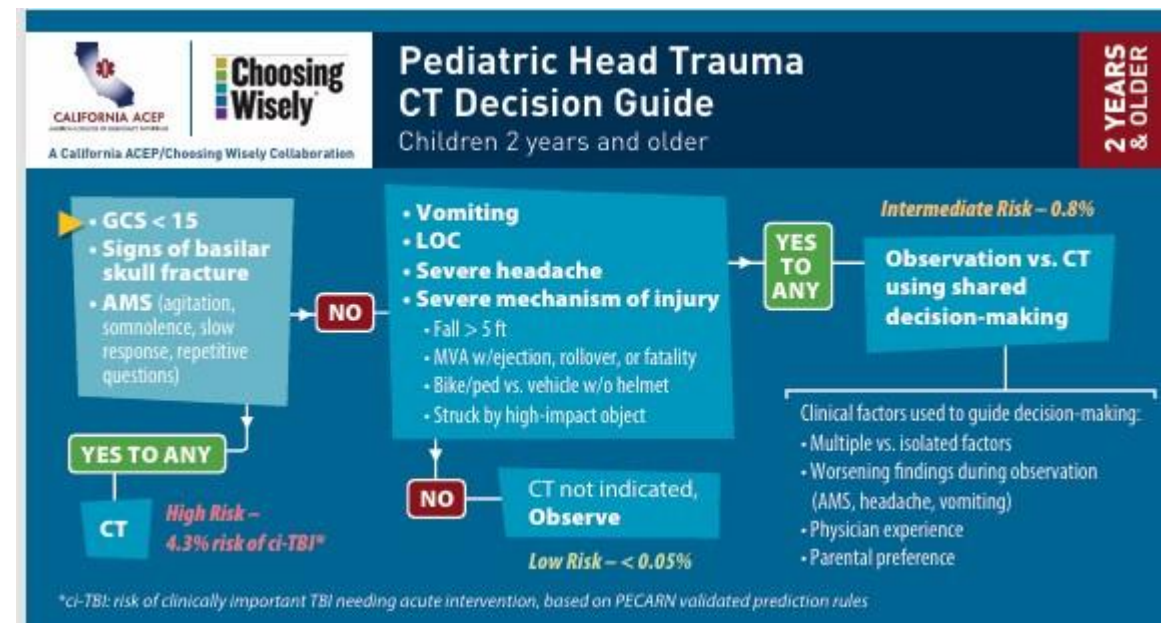
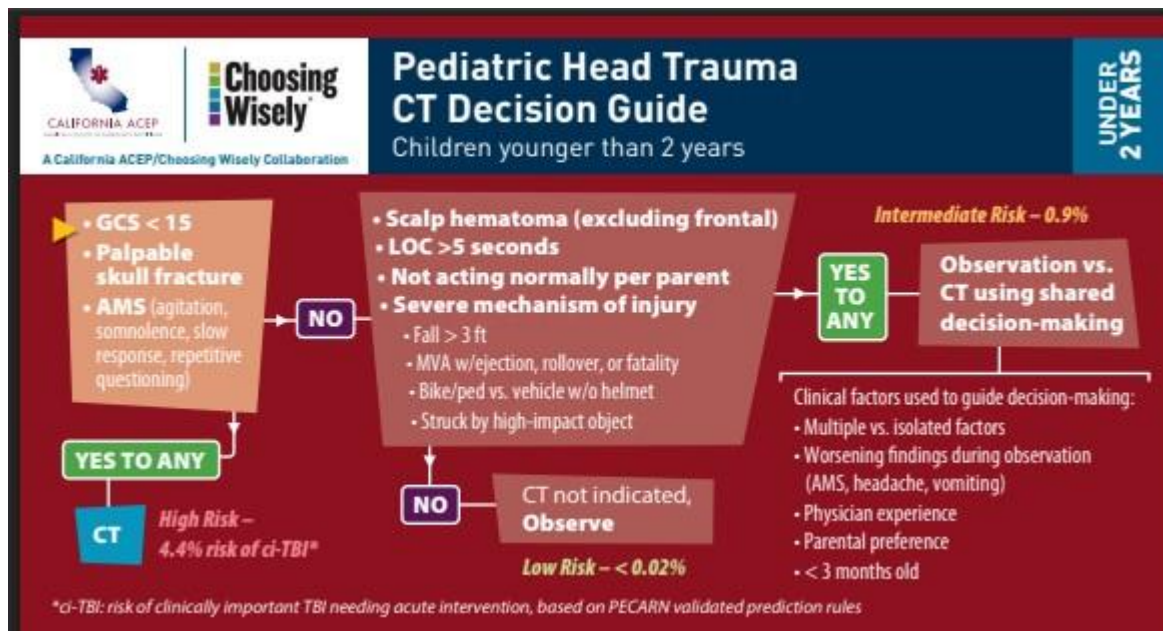
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or



18-month-old fell while seated in grocery cart. He was briefly unresponsive, eyes rolled up, then cried immediately. Vomited once. Injury 2 hrs. PTA.

Playful toddler with 3x3 cm right forehead hematoma. Rest WNL.



PECARN Minor Head Injury Risk Assessment





Management of BHT

- ❑ ***Intermediate* risk (0.9%) – Observation vs. CT using shared decision making**
- ❑ ***Low* risk (0.02%) – CT not indicated**

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or



56 days old, FT, NSVD, felt warm, fussy. Feeding well. Sibling has a "cold".

Exam –

Vigorous. T =101°F (rectal). Social smile (+). No focus for infection.

POCT

Urine Dip → neg

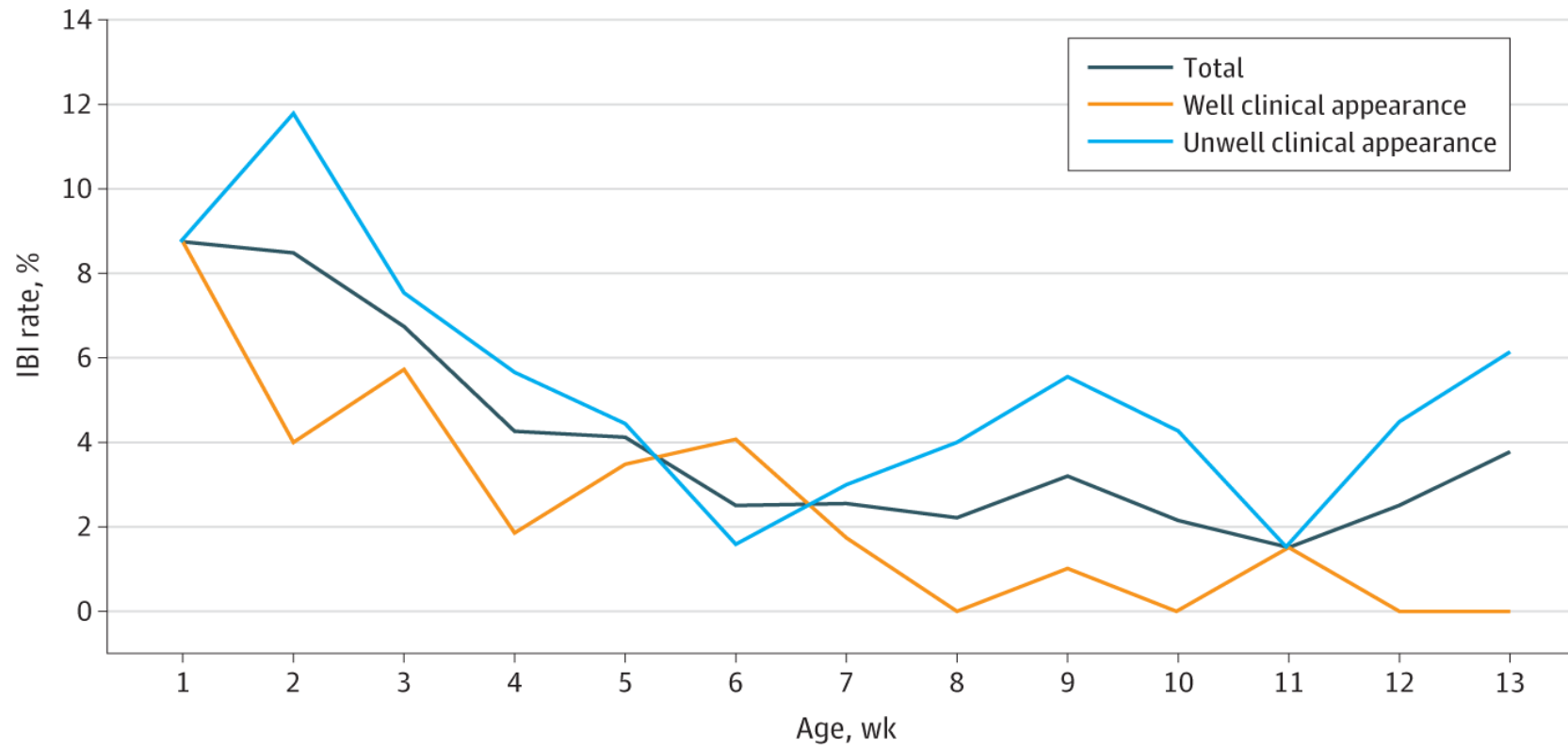
Influenza B → (+)



Category	Prevalence in 2 nd month (29-60 day old)	With (+) Influenza or RSV
Serious Bacterial Infection (SBI = IBI, UTI, PNA)	Majority are UTI 5-10%	Risk → Lower
Invasive Bacterial Infection (IBI = OB, Meningitis)	<input type="checkbox"/> Occult Bacteremia (1.1-2.2%) <input type="checkbox"/> Meningitis (0.12-0.32%)	<input type="checkbox"/> 1% <input type="checkbox"/> 0%

From: **Prevalence of Invasive Bacterial Infection Among Febrile Infants Aged 61 to 90 Days**

JAMA Netw Open. 2025;8(4):e257710



Robert H. Pantell, et al; SUBCOMMITTEE ON FEBRILE INFANTS,
Evaluation and Management of Well-Appearing Febrile Infants 8 to 60 Days Old.
Pediatrics August 2021; 148 (2)



Inclusion Criteria	May be Included	Study Excluded....
8-60 days	(+) Viral test	High concern for HSV
Well-appearing	AOM	Clinical bronchiolitis
> 37 wk.	Diarrhea (unless bacterial dysentery)	Received immunization < 48 hrs.
T > 100.4 in past 24 hrs. (home or office)		Perinatal ABX, maternal fever
Previously healthy		Focal bacterial infection



Risk Stratify

Low Risk

T < 38.5 C + ANC < 4K
+ CRP < 2 mg/dl

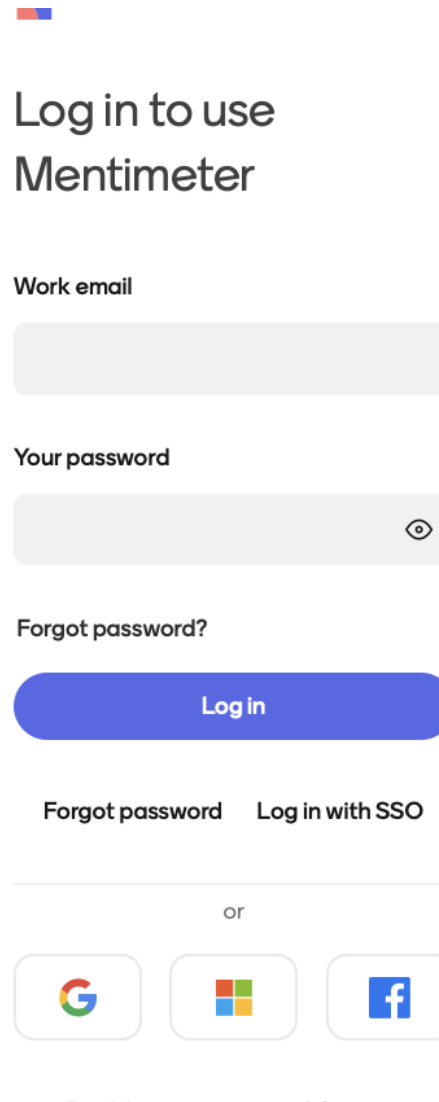
or

ANC < 5.2K + PCT < 0.5
ng/ml

Test	8-21 days	22-28 days	29-60 days
Urine	Y	Y	Y
UC	Y	Y if UA +	Y if UA +
BC	Y	Y	Y
IM	+/-	Y	Y
CSF	Y	Y if IM + or desired	Y if IM +
Disposition	Admit	DC if CSF & UA (-), 24 hrs. F/U	DC, 24 hrs. F/U

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or

Parents of 11 mo. old advised to introduce new foods. Today, had cashews, developed “*hives*” and vomiting. No respiratory distress or wheezing. Received *Benadryl* PTA.

Exam –

VS normal. Sleeping but easily arousable and interactive. Urticarial rash on face and trunk. Upper lip swelling, licking lips. Rest WNL.

Anaphylaxis Clinical Support Tool



Anaphylaxis definition, overview, and clinical support tool: 2024 consensus report

Study Summary

- A 46-member expert panel developed a consensus anaphylaxis definition, overview, and clinical support tool based on feedback from medical and patient advocacy organizations.
- The outputs are designed to be generalizable to different medical fields and to help standardize research outcomes.

Consensus anaphylaxis definition



Anaphylaxis is a serious allergic (hypersensitivity) reaction that can progress rapidly and may cause death. It may involve the skin/mucosa (includes lip/tongue), respiratory (lungs, breathing), cardiovascular (heart, blood pressure), and/or gastrointestinal (stomach/gut) systems. Life-threatening anaphylaxis is characterized by respiratory and/or cardiovascular involvement and may occur without skin/mucosa involvement.

Consensus anaphylaxis overview



The overview conveys important anaphylaxis information, including anaphylaxis presentations, distinct infant findings, common allergens, courses, outcomes, pathogenesis, diagnosis, and management.

Anaphylaxis Clinical Support Tool

For Healthcare Professionals

Anaphylaxis is likely when any one of the following three criteria are fulfilled

- No Known[†] Allergen Exposure**
Sudden onset of an illness (minutes to several hours) with **Skin / Mucosal** involvement AND either:
 - Respiratory involvement
 - Cardiovascular involvement
- Likely or Known[†] Allergen Exposure**
Sudden onset of two or more of the following:
 - Skin / Mucosal involvement
 - Respiratory involvement
 - Cardiovascular involvement
 - Severe Gastrointestinal involvement[‡]
- Known[†] Allergen Exposure**
Sudden onset of either:
 - Respiratory involvement after exposure to a non-inhaled allergen
 - Cardiovascular involvement

Intramuscular Epinephrine / Adrenaline*

- Should be given immediately for suspected anaphylaxis
- Can be given for patients that do not yet fulfill the criteria, based on clinical judgement

Administer in the middle third of the anterolateral thigh; repeat every 5-15 minutes if the patient does not respond

Manual	Auto-injectors
• 0.01 mg/kg = 0.01 mL/kg of 1 mg/mL (1:1000) solution	• < 13 kg: 0.1 mg or 0.15 mg
• Max single dose 0.5 mg	• 13 to < 25 kg: 0.15 mg
	• ≥ 25 kg: 0.3 mg (≥ 50 kg: 0.3 mg or 0.5 mg)

Anaphylaxis Organ Systems[§]

Skin
urticaria, flushing, erythema, facial swelling
Infants may also have mottling

Mucosal
lip, tongue, or oropharyngeal swelling, severe throat tightness, difficulty swallowing
Infants may also have repetitive lip licking

Respiratory
wheezing, increased work of breathing[†], hypoxemia, cough, dyspnea
Laryngeal: stridor, voice change
Infants may also have a hoarse cry

Cardiovascular
hypotension, syncope, dizziness, unexplained change in mental status
Infants may also have persistent unexplained tachycardia

Gastrointestinal
severe crampy abdominal pain, repetitive vomiting, diarrhea

Clinical support tool



New clinical criteria to help determine the likelihood that patients are having anaphylaxis.

Intramuscular epinephrine / adrenaline indications and dosing.

Common findings from the anaphylaxis organ systems.



Observation – how long?

“A **2-hrs.** observation period is probably safe for most children who present to an ED with an acute allergic reaction requiring epinephrine.

A **4-hrs.** observation period might be enough for patients with cardiovascular involvement who appear well.”

Dribin TE et al; PEM CRC of the American Academy of Pediatrics. **Timing of repeat epinephrine to inform paediatric anaphylaxis observation periods: a retrospective cohort study.** *Lancet Child Adolesc*



Anaphylaxis Action Plan

Watchful Waiting Approach
(+/- EMS) – *complete, prompt, durable response*




Alternative Epinephrine Routes

Infants & Toddler vs. older

ANAPHYLAXIS ACTION PLAN


A total of n=229 stakeholders assessed the AAP, noting good acceptability, high decisional self-efficacy (mean score 86.2/100, sd 15.9) and moderate decisional conflict (mean score 43.7/100, sd 18.8). Decisional conflict was unrelated to past anaphylaxis or epinephrine use. Information content was clear and sufficiently explained options with balanced and without a "best choice" bias. Overall, 86% of respondents would recommend using this AAP.


Recent advances in anaphylaxis

- 1**
The 'watchful waiting' approach

- 2**
The alternative epinephrine route

- 3**
The infant/toddler symptoms and signs



Key points

THE 'WATCHFUL WAITING' APPROACH






 Immediate activation of EMS may not be required if the patient experiences prompt, complete, and durable response to treatment with epinephrine, provided that additional epinephrine and medical care are readily available, if needed.

 We suggest that clinicians counsel patients to always activate EMS after epinephrine use if anaphylaxis is severe, fails to resolve promptly, fails to resolve completely or nearly completely, or returns or worsens after a first dose of epinephrine.

ALTERNATIVE EPINEPHRINE ROUTES

 Intranasal epinephrine may be used as an alternative to injectable epinephrine for the treatment of anaphylaxis.

ANAPHYLAXIS IN INFANTS AND TODDLERS

     Organ-specific reaction symptom presentations need to be tailored by age for older children vs. infants and toddlers

Seizure in WR



- 9-month-old presented for fever of **104°F**.
- Has a GTC **seizure**
- Call 911
- Monitors – SpO₂
- A-B-C
- **IM Midazolam** (0.3 mg/kg), if seizure > 5 min

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16 yrs. old
with h/o
depression
and anxiety,
screens
“moderate
risk” for
suicide on
the C-SSRS

C-SSRS

Do's/Don'ts

- **Check in regularly–**
 - ***Are you okay? Are you having any thoughts of wanting to hurt yourself?***
 - ***I'm concerned because I'm noticing [concerning behavior]***
 - ***You are not alone***
 - ***Are you going to hurt yourself or commit suicide?***
- **Do NOT say –**
 - ***“You should not feel this way”***
 - ***“You have a lot to be grateful for”***

Suicide Prevention Hotlines	Washington DC	Maryland	Virginia
Crisis Helpline: Call or Text 988	Access HelpLine: 1-888-793-4357	Maryland Crisis Hotline: 1-800-422-0009 OR 2-1-1, Press 1	Crisis Link: 703-527-4077 OR text CONNECT to 855-11
Línea de Prevención del Suicidio y Crisis: 1-888-628-9454	ChAMPS (Child and Adolescent Mobile Psychiatric Service): 202-481-1440	PG County Mobile Crisis: 301-927-4500 OR 988	Merrifield Center Emergency Services: 703-573-5679
TTY Users: Dial 711 then 988	DC Community Response Team (adult): 202-673-6495	Montgomery County Crisis Center for MD: 240-777-4000	Children's Regional Crisis Response: 844-N-Crisis (844-627-4747)
LGBT Youth Suicide Hotline: 1-866-4-U-TREVOR	DC Emergency Psychiatric Services: 202-561-7000	Maryland Behavioral Assessment Unit (Baltimore County): 410-931-2214	
Crisis Text Line: Text HOME to 741-741			

[Safety Plan_English.pdf](#)



Takeaways....

- **PECARN clinical decision rule for ciTBI after minor BHT**
- **AAP Guidelines for well appearing febrile 8-60 days old**
- **Anaphylaxis Action Plan**
- **Seizures – A-B-C, IM Midazolam**
- **C-SSRS Screen, Suicide Safety Plan**

