National Institute for Health and Clinical Excellence

Feverish Illness in Children (update)
Scope Consultation Table
2nd August 2011 – 31st August 2011

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	3M Health Care	1	4.3.1	Thermometers and the site of temperature measurement should be included in the scope of the update. The 2007 NICE Guideline provided inappropriate guidance regarding the use of Dot Matrix Thermometers when it stated that the use of these devices was not preferred in neonates. This review is an opportunity to address this error and to ensure that this patient group will benefit from the accurate temperature readings that axial use of dot matrix thermometers provide, to better instruct patient care.	Thank you for this comment The GDG reached their recommendations in the 2007 guideline based on a review of the available literature and economic evaluation plus a formal consensus process. We are not aware of any significant new evidence on this device that has been published since. Therefore, this question with not be included in the update.
SH	3M Health Care	2	4.3.2	Thermometers and the site of temperature measurement should be included in the scope of the update since misleading recommendations are contained in these sections of the original guideline. The 2007 NICE Guideline provided inappropriate guidance regarding the use of Dot Matrix Thermometers when it stated that the use of these devices was not preferred in neonates. This update of the guideline is an opportunity to address this error and to ensure that this patient group will benefit from the accurate temperature readings that axial use of dot matrix thermometers provide, to better instruct patient care. We do not believe that the recommendation to exclusively use electronic thermometers in patients less than 4 weeks of age, is supported by the published evidence. Nor has the 2007 Guideline process demonstrated that there is a consensus among UK clinicians that this is the only method	Thank you for this information. The GDG reached their recommendations in the 2007 guideline based on a review of the available literature (including the papers quoted here), economic evaluation and a formal consensus process.

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				of choice for temperature measurement in this age group. There are several published studies demonstrating the accuracy of chemical dot thermometers in the paediatric population that include neonates in the study population. The authors of studies that include a substantial proportion of patients less than 4 weeks old do not record any concerns with the axial use of dot matrix thermometers in this patient group[1,2]. In fact quite the contrary is true. In the large study[1] including over 1,400 data recordings and a median patient age of 8 days, 71% of axillary temperature measurements were within ±0.2 °C of the mercury/glass reading, the highest proportion for any of the 5 clinical thermometers tested in this study of temperature measurement in neonates. References 1. Leick-Rude MK, Bloom LF. A comparison of temperature-taking methods in neonates. Neonatal Network – Journal of Neonatal Nursing 1998;17(5):21–37 2. Rogers M. A viable alternative to the glass/mercury thermometer. Paed. Nursing 1992;4 (9) 8-11	
SH	3M Health Care	3	4.3.2	Include in the scope a review of the evidence supporting electronic thermometers in the under 5 age group. Evidence supporting the use of electronic thermometers is not reviewed in the guideline and the authors seem to have taken the approach that they are the equivalent of mercury/glass thermometers without presenting any evidence to support this assertion. Clearly the technologies used to measure temperature between electronic and mercury/glass are radically different and such an assumption is unwarranted and this area should be subject to review in	Thank you for this comment. The 2007 guideline explained that UK health and safety regulations means mercury thermometers are no longer used in the NHS. The guideline therefore sought to review alternatives, fully accepting that there would be differences.

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				the update process and advice added to updated guideline.	
SH	3M Health Care	4	4.5	Review of the health economic assessment of temperature measuring devices should be included in the scope of the update. The advice in section 1.1.2.3 (NICE guideline) "Healthcare professionals who routinely use disposable chemical dot thermometers should consider using an alternative type of thermometer when multiple temperature measurements are required" is misleading. The health economic assessment of different product types for measurement of temperature in paediatric patients is crude and not based on any meaningful data from published evidence other than initial product cost. The authors make an assumption that the clinician simply stays with the patient while the temperature reading is taken rather than doing any other useful work. The costs for cleansing, changing of batteries and recalibration of electronic and tympanic temperature measurement devices are not considered. The authors do not consider that replacement of an electronic or tympanic thermometer would be required before 10 years of continual use in a busy ward situation, without any evidence to support.	Thank you for this comment. The GDG is not aware of any recent studies that would provide the kind of analysis that you refer to; that is, publicly available data from trials providing more detailed comparative analysis of the costs and accuracy of alternative temperature measurement devices. Health economic analysis in NICE clinical guidelines reflects the data that is available, either from published research or, when that is not available, from GDG expert opinion. That expert opinion is based on the use of specific interventions in clinical practice. It is, by nature, a basic analysis where no other more robust, unbiased information is available. We are not aware of any significant new evidence on temperature measuring devices that has been published since the previous guideline. Therefore, this question with not be included in the update.
SH	Department of Health	1	General	The Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your interest in this guideline.
SH	McNeil Products Ltd	1	General	McNeil Products Ltd welcomes the opportunity to comment upon the scope of a review of clinical guideline CG47 on feverish illness in children. In the UK, McNeil Products Ltd markets and is the Marketing Authorisation Holder for a range of products marketed under the Calpol (paracetamol) and Calprofen (ibuprofen) brands, indicated for the symptomatic treatment of fever in children.	Thank you for your interest in this guideline.

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				Calpol has been available in the UK for over 40 years and is the bestselling children's pain and fever medicine with a consumer value of £48M and 63% value market share. It has a range of sub-brands which allow for treatment of pain and fever from 2 months to 12 years. Calpol is the paediatric analgesic / antipyretic brand most widely recommended by healthcare professionals.	
SH	McNeil Products Ltd	2	4.3.1 d)	Our comments are as follows: - The term "non-steroidal anti-inflammatory drugs (NSAIDs)" presumably refers to ibuprofen. This should be clarified. - Fever can occur as a symptom associated with a large number of different conditions. Therefore it would not be appropriate to consider these as one illness. If good evidence is uncovered that symptomatic drug treatment of fever affects outcome for one specific illness, this should not be considered to mean that this is the case with other illnesses	Thank for these comments. 1. We agree the term NSAIDs includes ibuprofen and it is correct that this is the most commonly used NSAIDs in this age group. However, evidence may be available on other types of NSAIDs so using the term ibuprofen would be restrictive. 2. Where possible the potential attenuating effect of antipyretics drugs on serious illness will be examined on the condition-by-condition basis. Recommendations will not be made without supporting evidence.
SH	McNeil Products Ltd	3	4.3.1 e)	Our comments are as follows: - The term "non-steroidal anti-inflammatory drugs (NSAIDs)" presumably refers to ibuprofen. This should be clarified.	We agree the term NSAIDs includes ibuprofen and it is correct that this is the most commonly used NSAIDs in this age group. However, evidence may be available on other types of NSAIDs so using the term ibuprofen would be restrictive.
SH	McNeil Products Ltd	4	4.3.1 f)	Our comments are as follows: - The term "non-steroidal anti-inflammatory drugs (NSAIDs)" presumably refers to ibuprofen. This should be clarified. - Effect on fever and associated symptoms of	Thank you for your comments 1. We agree the term NSAIDs includes ibuprofen and it is correct that this is the most commonly used NSAIDs in this age group. However, evidence may

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				treatment with paracetamol and/or ibuprofen should be balanced with the safety profile of the treatment. Any recommendation should reflect the benefits versus risks of each drug - "Alternating paracetamol and NSAIDs" could be taken to cover a number of different scenarios, and it is important to be precise in the terminology used to avoid confusion, and to ensure that evidence is considered for every scenario. "Alternating therapy" could refer to: o 1. A fixed dosage regimen involving alternating two drugs, given at set times whether or not symptoms are present o 2. "As needed" alternating use of two drugs used alternately, with doses only given if fever / discomfort is present o 3. "Step-up" therapy, where the first drug has not provided symptomatic relief and use of a second drug is considered. Advice contained within the current guidance appears to relate more to this scenario. - When considering the evidence on these various scenarios, irrespective of the strength of the evidence, advice is needed on the appropriate action when symptomatic treatment of fever has not been achieved with the use of a single drug alone	be available on other types of NSAIDs so using the term ibuprofen would be restrictive. 2. Both clinical risks and benefits will be assessed. 3. We are aware that the general comparison headings we have provided covered a range of more precise comparisons. We will take note of the combinations outline here and where evidence is available these combinations will be examined. 4. Where appropriate the guideline will give advice on what action to take if symptoms persist after treatment.
SH	McNeil Products Ltd	5	4.3.1 g)	Our comments are as follows: - The term "non-steroidal anti-inflammatory drugs (NSAIDs)" presumably refers to ibuprofen. This should be clarified.	We agree the term NSAIDs includes ibuprofen and it is correct that this is the most commonly used NSAIDs in this age group. However, evidence may be available on other types of NSAIDs so using the term ibuprofen would be restrictive.

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				- We agree that guidance recommendations should normally fall within licensed indications. However, this needs to be correctly interpreted. Recommendations should not be *inconsistent* with licensed indications, but may not be explicity referred to within licensed indications. For example, licensed indications may not explicity refer to certain dosing scenarios, including using combinations of more than one drug in the symptomatic treatment of fever. However, recommending these combination dosing regimens would not necessarily be inconsistent with the Summaries of Product Characteristics (SmPCs) for the respective drugs. Therefore, given appropriate evidence, this should be reflected in the guidance	
SH	McNeil Products Ltd	6	4.4	Our comments are as follows: - Symptomatic relief of fever and associated symptoms such as discomfort should be explicity included as an outcome	Thank you for this comment. This has been made more explicit in the scope.
SH	Medicines and Healthcare products Regulatory Agency	1	4.1.2 b)	The MHRA considers that "pre-existing co morbidity" should be defined more clearly when defining groups that will not be covered by the guideline. In addition to cystic fibrosis and immunosuppression, children with sickle cell disease and cerebral shunts should also be considered.	Thank you, these groups will be added to the list of co-morbidities.
SH	Medicines and Healthcare products Regulatory Agency	2	4.3.1 a)	The predictive value of the following symptoms and signs should also be discussed: abdominal pain, offensive urine or haematuria (UTI), conjunctival injection and upper respiratory tract mucosa changes (Kawasaki disease).	Thank for these comments. The symptoms and signs mentioned here are already included under the 'Symptoms and signs of specific serious illness' section of the 2007 guideline (p. 46).

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					Therefore, they will not be added to the list of non-specific symptoms and signs that may indicate serious illness.
SH	Medicines and Healthcare products Regulatory Agency	3	4.3.1 f)	The recently published new guidance on paracetamol dosing should be included in this section. www.mhra.gov.uk/NewsCentre/Pressreleases/CON120251	Thank for this information. The full guideline document will make reference to existing standards and regulations.
SH	Meningitis Trust	1	General	We have reviewed the scope and do not have any further comments	Thank you for your interest in this guideline.
SH	Meningitis UK	1	3.1 b)	Although there is obvious evidence to support the guidelines focusing on children younger than 5 years (i.e. 3.2 (a) rapid changes in younger children), there is a significant proportion of children aged between 5 and 15 years, specifically one in five, who have consultation for feverish illness. Would the presentation and management of feverish illness in this group be so distinctive that it could not be covered in the guidelines?	Thank you for this comment. As this is an update of the 2007 guideline we are restricted to children aged 0 to 5 years as outlined in the original remit from the Department of Health.
SH	Meningitis UK	2	4.1.1 a)	The comment that children presenting with 'a fever that has not been previously diagnosed' will be covered by the scope may be problematic. Diagnosed by whom? What about misdiagnosis? Meningitis UK encounter many parents whose concerns over their child's health have been disregarded by healthcare/medical professionals.	Thank for your comment. We agree misdiagnosis is an important issue, and the main aim of the guideline is to reduce possible misdiagnosis by providing clear criteria for assessment.
SH	Meningitis UK	3	4.1.2 c) / 4.3.1 (a)	4.1.2 (c) states that 'children with recurring and/or persistent fever' will not be covered by the guidelines, whereas 4.3.1 (a) states that 'persistent fever (5 days or more)' will be considered as an initial indicator of serious illness. Does this need further clarification to avoid contradiction?	Thank for your comment. These statements have been clarified in the scope to avoid contradiction.
SH	Meningitis UK	4	4.3.1 a)	The first three bullet points carry a degree of subjectivity (i.e. *abnormal* skin colour, *appearing* ill, *altered* responsiveness or cry). Meningitis UK often encounters parents who have sought medical care due to these subjective factors, and we	Thank you for these comments. The aim of the guideline will be to determine which signs and symptoms have evidence available to support their

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				regularly advise people to trust their instinct as they know their child best. Unfortunately, the subjective nature of these clinical indications can be met by scepticism, especially if the parent is not able to confidently articulate their opinion (perhaps due to education, ethnicity etc.)	inclusion, including "appearing ill to a parent/carer". Equality is central to NICE guideline development and is taken into account in each question. We will ensure that the issues raised are taken into account when this question is discussed.
SH	NHS Direct	1	4.3.1 a)	NHS Direct has discussed the use of being offered temperature recordings during remote assessment in particular that we cannot confirm the validity of the temperature recording given to us by the caller during a tele-consultation. The current guidance emphasises the appearance of the child, if a high temperature is given. We would like the scope to consider remote assessment and the validity of temperature recordings given by callers.	Thank for your comment. Temperature recording was examined in the original guideline, and we are not unaware of any new evidence on this area. Therefore, this question will not be covered in this update.
SH	NHS Direct	2	4.3.1 a)	• *"limb or joint swelling* • *unwillingness to weight bear or to use a limb"* In addition to the above 2 could the scope look at the relevance of including limb or joint pain with no history of injury?	Thank you for this comment. We will take note of these and they will be examined if evidence is found in relation to non-specific symptoms and signs of serious illness.
SH	NHS Direct	3	4.3.1 f)	Any guidance regarding the use of paracetamol and/or ibuprofen needs to be absolutely clear as there appeared to be a lot of confusion following the previous guidance release, especially as to whether the advice was about children with fever as a lone symptom or fever + other symptoms. We would like to see very clear guidance for fever management for example if a cough is present and therefore fever can be related to a cough give the following:	Thank for this comment. We will take note of this comment and highlight it when this question is discussed during the guideline development.

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				For example: Initially start on Paracetamol or Ibuprofen, if no effect, add the other medicine. If Pyrexia of unknown origin and if one medicine fails to lower the temperature go to GP.	
SH	NHS Direct	7	4.3.1 a)	Should second bullet have parent / carer?	Thank you This change has been made.
SH	NHS Direct	4	4.3.2 g)	*"Management by remote assessment."* This is a clinical issue that will NOT be covered what happens to the recommendations from the previous guidance? There is already a great deal of confusion and contradiction, and this will add to it – especially in light of remote assessment accounting for 4.5 million calls to the telephone service and 7.5 million to the online self assessment. Top reasons are - Colds and flu, Abdominal pain, D&V amongst others, all of which have association with fever.	Thank you. To clarify: recommendations that are not updated will remain valid and will be included in the updated guideline. In addition, consideration will be given to if new or updated recommendations need to vary by setting.
SH	NHS Direct	5	4.3.2 g	Remote assessment is outside scope but experience from NHS Direct indicates that it is important to ensure follow up is within tight parameters with young children. Current NICE guidance advises 5 days after initial contact with health care professional before seeking further advice. Remote assessment depends on "interpretation of symptoms" and so is 5 days too long before a further contact face to face should be made to carry out more detailed assessment of physical signs?	Thank you for this comment. Based on literature searches, we are not aware of any significant new evidence on this area that has been published since the 2007 guideline. Therefore, this question with not be included in the update.
SH	NHS Direct	6	4.3.2 i	Scope says it will update sections in line of any new recommendations and so will require updating to encompass clear advice on use of paracetamol and/or NSAIDs. Consideration should also be given to time frame before	Thank you for this comment. The update will be examining the use of paracetamol and/or NSAIDs.

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				advise parent/carer to seek further advice if no improvement – see comment 5 above.	The 2007 makes a recommendation on the duration of waiting in conjunction with other factors. "Following contact with a healthcare professional, parents and carers who are looking after their feverish child at home should seek further advice if: • the child has a fit • the child develops a non-blanching rash • the parent or carer feels that the child is less well than when they previously sought advice • the parent or carer is more worried than when they previously sought advice • the fever lasts longer then 5 days • the parent or carer is distressed, or concerned that they are unable to look after their child" (p. 23 of full guideline)
SH	RCGP	1	General	The scope for this consultation appears comprehensive and importantly relevant to general practice. The symptoms and signs mentioned in the scope are seen commonly in day to day practice and so it could be a useful if a potential output is a robust predictive scoring system.	Thank you for your interest in this guideline.
SH	Royal College of Nursing	1	General	Nurses working in this area of health have reviewed the above mentioned NICE guideline. There are no further comments to submit at this stage on behalf of the Royal College of Nursing.	Thank you for your interest in this guideline.
SH	Royal College of Paediatrics and Child	1	General	Looks sensible.	Thank you for your interest in this guideline.

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	Health				
SH	Royal College of Paediatrics and Child Health	2	General	Main areas to be covered are ideal. Our concern is whether we need to review different ages and proportional pyrexia – i.e. does temperature of 38 at 1 month confer more risk than temperature of 38 at 3 months, to ensure a clear cut off for the traffic lights at age, particularly for our colleagues in primary care using this guideline.	Thank you for this comment. This issue was addressed by the age related recommendations in traffic lights table in the 2007 guideline of the original guideline (p. 35 of full guideline).
SH	Royal College of Paediatrics and Child Health	3	General	Clearly febrile illness in children is a very important area by virtue of its commonality, protean findings and potential consequences if improperly treated. We would like to see more evidence and guidance on febrile children with rash. The strength of evidence on rash morphology and distribution would help.	Thank you for this comment Rash was examined in the 2007 guideline and is included in the list of non-specific symptoms and signs.
SH	Royal College of Paediatrics and Child Health	4	General	Agree with defined scope of this updated guideline scope as these are the clinically relevant questions that are faced by doctors and nurses managing patients.	Thank you for this comment.
SH	Royal College of Paediatrics and Child Health	5	4.1.1	Children less than 3 months should be considered as a special group.	Thank you for this comment This group is already specified in the original guideline.
SH	Royal College of Paediatrics and Child Health	6	4.3.1	To be consistent please put "abnormal respiratory rate (below or above normal limits)" instead of "respiratory rate", "prolonged capillary refill time (>2seconds)" instead of "capillary refill time", "high grade pyrexia (>39.5)" instead of "height of fever". Please add "hypothermia (low core body temperature)" as an indicator of serious illness to be covered.	Thank you. The suggested changes have been made to the document. However, we will not be able to give specific amounts as these will be determined on the available evidence. As this question is examining non-specific symptoms and signs in children with feverish illness, we will not add hypothermia to the list.

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SH	Royal College of Paediatrics and Child Health	7	4.3.1 a	The list is a self-evident group of features that point to significant illness. We are not sure what "evidence" for predictive value would add in terms of case management.	Thank you. Whilst the list is 'self-evident' the actual usefulness of any one feature may vary and this needs to be examined.
SH	Royal College of Paediatrics and Child Health	8	4.3.1	Other laboratory markers should be included, e.g. neutropaenia/leucopaenia in full blood count.	Thank you for this comment. These were examined in the 2007 guideline and we are not aware of any new evidence. Therefore they will not be examined as standalone tests in this update. However, these tests will be examined if they are used in combination with either pro-calcitonin and/or C reactive protein.
SH	Royal College of Paediatrics and Child Health	9	4.3.1 b,c,e	Seem useful additions.	Thank you for your comment
SH	Royal College of Paediatrics and Child Health	10	4.3.2	The correct and safe use of temperature measurement should be included as this is an essential part of the assessment of a feverish child. There is a varying degree of practice with regard to temperature measurement. False readings are not uncommon depending on the device/technique used. This will influence subsequent management decisions.	Thank you for this comment. The 2007 guideline included the assessment of evidence on the routine use and accuracy of different types of thermometers. In addition, staff should be fully trained in the use of any equipment they need in their work.
SH	Royal College of Paediatrics and Child Health	11	4.4 e	Is likely to be useful.	Thank you for your comment

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