Feverish illness: assessment and initial management in children younger than 5 years of age (update)

Summary of Key Points raised at Stakeholder Guideline Scope Workshop – 7th July 2011

The objectives of the scoping workshop were to:

- obtain feedback on the key clinical issues included in the first draft of the scope
- identify which patient or population subgroups should be specified
- seek views on the composition of the guideline development group (GDG)
- encourage applications for GDG membership.

The scoping group (technical team, NICE and GDG Chair) presented a summary of the proposed scope, the timetable for guideline development, the guideline development process, the nature of stakeholder input into the guideline, the processes for recruitment to the GDG and a suggested constituency for this group. The stakeholder representatives were then divided into two groups which included a facilitator and a scribe, and each group had a structured discussion around the key issues.

Consideration on the draft scope:

- **Guideline title:**

There were no issues raised about the title of the guideline update; it the same as the 2007 guideline.

- **General comments:**

  It was suggested that the clinical questions should be phrased as in the original guideline (eg replace diagnostic accuracy and diagnostic value with predicting value).

  One attendee suggested that some of the terminology used in Traffic light system might benefit from reconsideration with a view to increasing clarity - for example "Child unresponsive to normal social cues."

  3.1 Epidemiology/Service use

  – Section A)

  There were no issues raised about this section

  – Section b)

It was suggested that it might be important to specify the wide range of settings where a child with fever might present (e.g. walk-in centres, remote assessment centres etc.)

  – Section c)

The fact that the introduction of vaccination programmes for pneumococcal infection would have changed the epidemiology of bacterial infections was discussed. It was agreed that this change would be best acknowledged in the Introduction to the guideline. It was not though that it was likely however to alter recommendations on management at this time.

General discussion took place about services and the efficiency of different services model (eg primary care nursing lead clinic); message that the health care provider gives to parent and cares about the necessity to continue to assess the illness even if the child is not, at a first assessment, not considered to be seriously ill (because the clinical picture often changes rapidly in young children) and implementation of the traffic light system.

- **4.1 Population**

All the discussion groups was happy with this section

- **4.3.1 Key clinical issues that will be covered**

Symptoms and signs:

It was agreed that this section should cover the all the items mentioned in the traffic light system, but in addition it would be useful to add blanching rash. CRT≥ 3 second is not useful alone but if used in combination with other symptoms and signs

- It was agreed that newly available scoring systems should be taken account not as sources of evidence but to help in considering the current traffic light

Heart rate

This section needs to be phrased as in the original guideline but the group agreed that was an important question.

Using pro-calcitonin and/or C reactive protein – agreed to be important

It was thought that it would be important to explain in 'current practice' section of the scope how these laboratory tests are currently used. This question needed to define the benefits and cost of these methods, for example how they might be used to avoid unnecessary antibiotic treatment and the importance of early detection of a serious illness.

Antipyretic agents

Regarding the use of antipyretic agents it was considered that it would be useful to consider the following aspects:

- How treating fever might affect the illness outcome?
- Whether the response to antipyretics may suggest that the underlying cause is or is not likely to be serious (e.g., if a child with fever becomes more alert and socially responsive with a fall in temperature)
- If antipyretics were used, what is the best type of treatment – paracetamol or non-steroidals or combinations of the two?
- Consider the advice given if fever continues

Other suggestions

One attendee suggested that as with heart rate, the diagnostic value of change in respiratory rate with body temperature might be worth considering

Some suggested that the safety netting advice might need modification in the light of new formats for advice.

It was suggested that current advice needs to be more specific in terms of when to take action

- **4.4 Main outcomes**
  - Mortality
  - Morbidity
  - Parents and carers satisfaction
  - Appropriate admission to hospital
  - Appropriate use of antibiotics (use/non-use of antibiotics)
  - Early detection of the illness
  - Accuracy of diagnosis
  - Acceptability/tolerability (of treatment)
  - Appropriate disposition (e.g. appropriate advice and treatment given)

- **Equality issues**

Possible quality issue to be covered are children with dark skin tone (detecting rash)

Membership of GDG

Proposed GDG composition
GDG chair (appointed)
- Martin Richardson, Consultant Paediatrician

Healthcare professional members

The meeting discussed the composition for the GDG and the following were suggested as being relevant.

- A consultant paediatrician
- A general practitioner
- Two nurses

- A specialist in paediatric infectious disease
- A emergency medicine health care professional (medical or nursing)
- A pharmacist

Parents/carer members

- Two parent/carers (may be from organisations that support parents/carers or individual parents/carers who have experience of caring for children younger than 5 years of age).

External advisers

- No specific suggestions were made here