

Treat Chronic Viral Hepatitis in Children?

ARTICLES BY
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SAN FRANCISCO — Although some therapies are available for treating chronic viral hepatitis, it remains unclear whether children should be treated, Frank R. Sinatra, M.D., said at a meeting on clinical pediatrics sponsored by the University of California, San Francisco.

There are good arguments on both sides of the issue, said Dr. Sinatra, director of the pediatric gastroenterology division at the University of Southern California, Los Angeles.

The arguments for treatment include the following:

- ▶ Early treatment can prevent fibrosis and cirrhosis.
- ▶ Children do at least as well as—and perhaps better than—adults, with current drugs.
- ▶ Treatment can help prevent the spread of chronic hepatitis B and hepatitis C.
- ▶ Many clinicians believe that any chronic viral infection must be eradicated.

The arguments against treatment include the following:

- ▶ Most children with chronic viral hepatitis are asymptomatic. “It’s very hard to make an asymptomatic patient feel good,” Dr. Sinatra said.
 - ▶ Fibrosis typically develops slowly.
 - ▶ The side effects from current treatments are significant, and include growth retardation.
 - ▶ Current therapy has a success rate of only 50%.
 - ▶ Even without treatment, a small number of children will experience spontaneous resolution of their chronic infection.
 - ▶ In Dr. Sinatra’s view, the best argument against treating children who appear to be doing well is that there are better drugs on the horizon. He knows of at least eight that are in phase I, phase II, or phase III clinical trials.
- Whether or not a clinician decides on treatment, these children need to be followed closely for evidence of progressive liver disease and the development of hepatocellular carcinoma, he said. ■

Appendectomies Sometimes Can Wait, Even After Perforation

SAN FRANCISCO — A perforated appendix in a child need not mean an immediate appendectomy, Hanmin Lee, M.D., said at a meeting on clinical pediatrics sponsored by the University of California, San Francisco.

Some clinicians say that some children do better by being sent home with IV antibiotics for a few weeks, followed by an elective appendectomy.

“It’s thought by some folks that there are fewer operative complications overall, because you’re dealing with a less angry appendix,” said Dr. Lee of UCSF. “Essentially, after 2 months it looks like a normal appendix, and the operation is very easy.”

Another argument for an “interval appendectomy” is that it may decrease total hospital time. An immediate appendectomy on a child with a perforated appendix typically means 2-3 weeks in the hospital. But if the child is treated in the hospital for several days with IV antibiotics and then sent home with a central line or a PIC (peripherally inserted catheter) line, the appendix may well quiet down.

After a couple of months the appendix will look normal, and the child may be able to go home the day after an elective appendectomy.

On the other hand, immediate surgery may involve less total sick time. With an interval appendectomy, “you’re committing these kids to essentially 2 months

of being kind of sick,” Dr. Lee said. “If you do an immediate appendectomy, they may be in the hospital for up to 2 or 3 weeks, but then they’re usually cured of their disease. There may [also] be a slightly decreased incidence of overall complications.”

About a quarter of the patients fail in the interval, becoming sicker and losing their appetite, and they must be brought back in for immediate surgery.

Unfortunately, there have been no good prospective studies comparing interval appendectomy with immediate appendectomy, Dr. Lee said. But there are a number of clues indicating when a patient may do well to wait, and when he or she should get immediate surgery. A patient who has been diagnosed within 3 days of the onset of symptoms should be treated like one with acute appendicitis and should get immediate surgery. But it’s possible that a patient diagnosed 4 days or more after symptom onset can wait.

A patient who appears to be doing well (no fever and able to eat) about a week after the onset of symptoms may have a well-formed, walled-off abscess that can be drained by an interventional radiologist. Such a patient may be a good candidate for interval appendectomy.

On the other hand, if the patient is sick with continued fever and anorexia, that’s an indication that there’s a diffuse process and that immediate appendectomy is warranted, Dr. Lee said. ■

Some children do better sent home with IV antibiotics for a few weeks, followed by an appendectomy, ‘because you’re dealing with a less angry appendix.’

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Imaging Can Aid Diagnosis Of Pediatric Appendicitis

SAN FRANCISCO — While imaging isn’t necessary in obvious cases of pediatric appendicitis, CT or ultrasound can be of great help in making a diagnosis, Hanmin Lee, M.D., said at a meeting on clinical pediatrics sponsored by the University of California, San Francisco.

The 10-year-old boy with right lower quadrant pain, McBurney sign, a slightly elevated blood count, and a low-grade fever can go straight to the operating room, said Dr. Lee of the university.

In other cases, imaging can be a very important aid to decision making.

Plain x-ray films are usually not too helpful except in one case: a chest x-ray can be useful to rule out right lower lobe pneumonia, especially if the child has some suggestive symptoms.

Both CT and ultrasound can be excellent diagnostic tools, and which to use often depends on institutional factors. CT tends to be more consistent from one institution to another, and as a static image, it’s easier for a third party to read.

Ultrasounds are more variable but can have the twin advantages of less time and expense, he said.

There are patient differences, however. “In a younger skinnier patient, an ultrasound is probably better,” Dr. Lee said. “In an older heavier patient, CT scan is probably better.”

Ultrasound and CT studies that come back “positive” can be relied on to be accurate, he said. But clinicians should quiz the radiologist with a study that comes back “negative.”

If “negative” means that a normal appendix has been identified, that’s probably accurate. But often “negative” actually means that the appendix has not been seen. This result would more accurately be called “indeterminate,” Dr. Lee said.

With CT, a clear positive would be a thickened tubular structure that filled with contrast. With ultrasound, a clear positive would be an incompressible, thick-walled, tubular structure, he said. ■

