11.00 – 12.15	**La sincope in età pediatrica** (Gabriele Bronzetti)
12.15 – 13.30	**Febbre, dolore, antibiotici, emergenza, asma, ecc: abbiamo sempre fatto così, ma ...** (Egidio Barbi)
13.30	Pranzo

Un antibiotico “tutte” le malattie: amoxicillina (clavulanico)

- tonsillite
- otite (precedente fall/trattamento amoxi)
- sinusite
- polmonite
- infezione vie urinarie
- gastroenterite da salmonella
- cellulite-eczema infetto

TABLE 4 Recommendations for Initial Management for Uncomplicated AOM[a]

Age	Otorrhea With AOM[a]	Unilateral or Bilateral AOM[a] With Severe Symptoms[b]	Bilateral AOM[a] Without Otorrhea	Unilateral AOM[a] Without Otorrhea
6 mo to 2 y	Antibiotic therapy	Antibiotic therapy	Antibiotic therapy	Antibiotic therapy or additional observation
≥2 y	Antibiotic therapy	Antibiotic therapy	Antibiotic therapy or additional observation	Antibiotic therapy or additional observation[c]

[a] Applies only to children with well-documented AOM with high certainty of diagnosis (see Diagnosis section).

[b] A toxic-appearing child, persistent otalgia more than 48 h, temperature ≥39°C (102.2°F) in the past 48 h, or if there is uncertain access to follow-up after the visit.

[c] This plan of initial management provides an opportunity for shared decision-making with the child's family for those categories appropriate for additional observation. If observation is offered, a mechanism must be in place to ensure follow-up and begin antibiotics if the child worsens or fails to improve within 48 to 72 h of AOM onset.

In concreto ?

- vigile attesa anche 6-24 mesi in quadro lieve
- NNT sotto i due anni e otite severa (bilaterale o otorrea) 4
- NNT generale 8-16
- NNT per prevenire mastoidite 4800
- 30% degli osservati finiscono in antibiotico
- amoxi sempre, clavulanico se terapia entro mese precedente

Journal of Paediatrics and Child Health

doi:10.1111/jpc.13864

INSTRUCTIVE CASE

Meningitis as a consequence of otitis media in a child referred from the newborn hearing screening programme: A missed opportunity

Lorenza Matarazzo [1], Silvia Nider,[2] Saba Battelino,[3] Enrico Muzzi,[2] Eva Orzan,[2] Alessandro Ventura[1,2] and Egidio Barbi[1,2]

[1]Clinical Department of Medical, Surgical and Health Science, University of Trieste, [2]Institute for Maternal and Child Health, Burlo Garofolo Pediatric Institute, Trieste, Italy and [3]University Medical Centre of Ljubljana and Medical School University of Ljubljana, Ljubljana, Slovenia

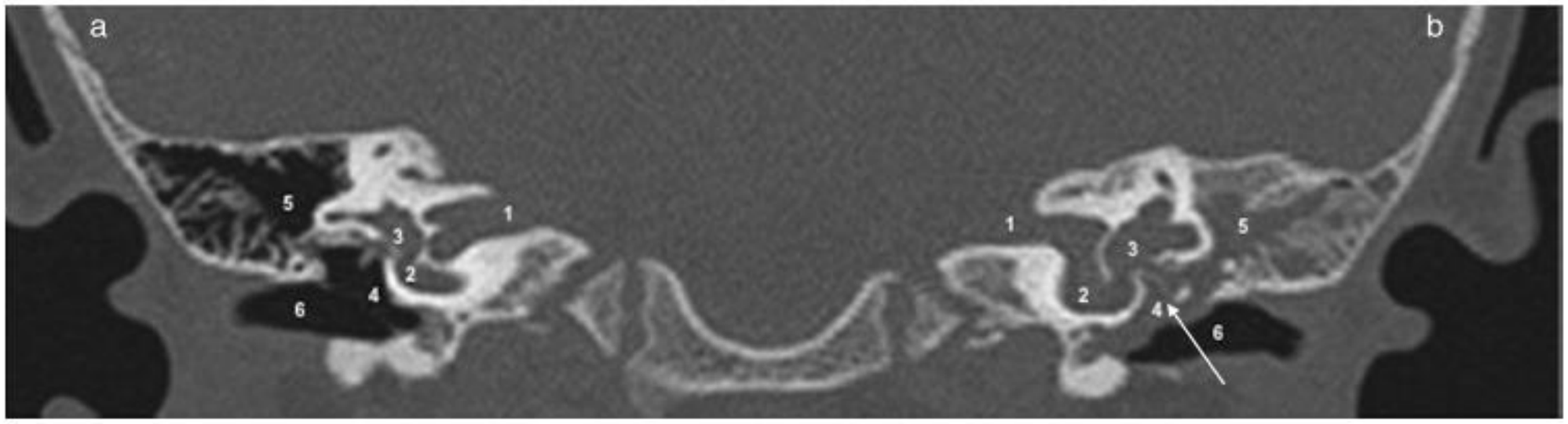


Fig. 1 High-resolution computed tomography of the head at the level of the temporal bones, coronal view. Left cochleovestibular malformation (incomplete partition type I, arrow) with communicating internal auditory canal (absent cribriform area), cystic cochlea and middle ear; note the oval window fistula through the dysplastic stapes' footplate, the tympanic cavity and mastoid filled with cerebrospinal fluid, the tympanic membrane bulging into the external auditory canal and the dysplastic vestibule and lateral semi-circular canal. Normal right ear anatomy. (a) Right ear; (b) left ear. 1, internal auditory canal; 2, cochlea; 3, vestibule at the level of the oval window (stapes' footplate) and lateral semicircular canal; 4, tympanic cavity; 5, mastoid; 6, external auditory canal.

Linee guida

La faringotonsillite in età pediatrica

Aggiornamento della Linea Guida della Regione Emilia-Romagna

SIMONA DI MARIO[1], CARLO GAGLIOTTI[2], MARIA LUISA MORO[2]
a nome del Comitato tecnico-scientifico regionale "Progetto ProBA 2014"*

[1]Centro di documentazione sulla salute perinatale e riproduttiva - SaPeRiDoc, Servizio Assistenza Territoriale, Direzione generale sanità e politiche sociali e per l'integrazione; [2]Area Rischio Infettivo, Agenzia Sanitaria e Sociale Regionale - Regione Emilia-Romagna, Bologna

SCORE CLINICO DI McISAAC PER IL SOSPETTO DI FARINGOTONSILLITE STREPTOCOCCICA

McIsaac score	Score
Temperatura ≥ 38 °C	1
Assenza di tosse	1
Adenopatia dolente laterocervicale anteriore	1
Tumefazione o essudato tonsillare	1
Età 3-14 anni	1
Totale	**0-5**

Tabella II

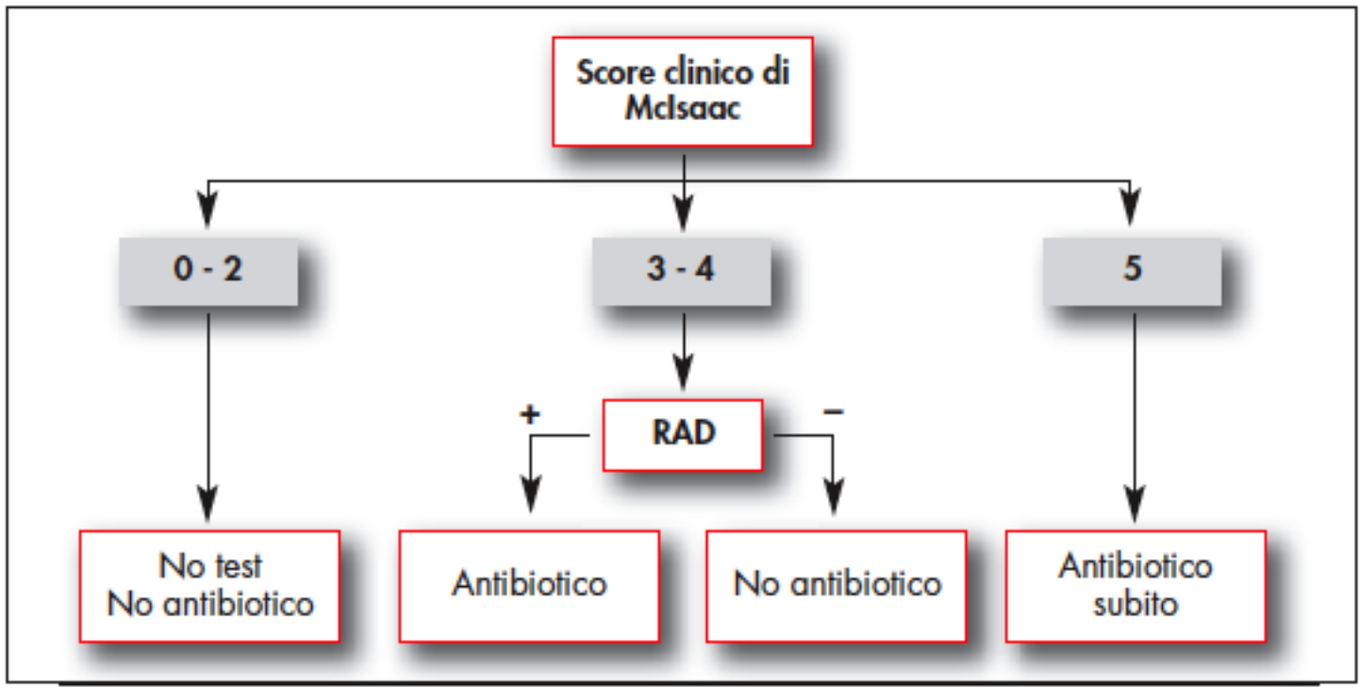


Figura 1. *Algoritmo diagnostico-terapeutico per le faringotonsilliti nel bambino.*

APPROPRIATEZZA DEI TRE MODELLI NELLA GESTIONE DEI BAMBINI CON MAL DI GOLA*

	Veri positivi	Veri negativi	Complessiva
Score + RAD°	78%	93%	87%
Score + coltura	81%	96%	90%
Score	81%	40%	55%

**Popolazione di riferimento: bambini con mal di gola (prevalenza di infezione/colonizzazione streptococcica = 37%); °sensibilità e specificità del RAD 95%*

Tabella III

il potere dell'ex iuvantibus.....

Come nella linea guida del 2007, la terapia raccomandata in caso di faringotonsillite streptococcica in Regione Emilia-Romagna è **l'amoxicillina, 50 mg/kg in due dosi al giorno per 6 giorni**

la valutazione dell'efficacia è su base clinica.

Se dopo 24 (-48) ore di trattamento i sintomi non migliorano l'origine streptococcica è ragionevolmente esclusa e **si può sospendere la terapia.**

Table 1 Recommendations regarding uroradiological imaging in children with UTI

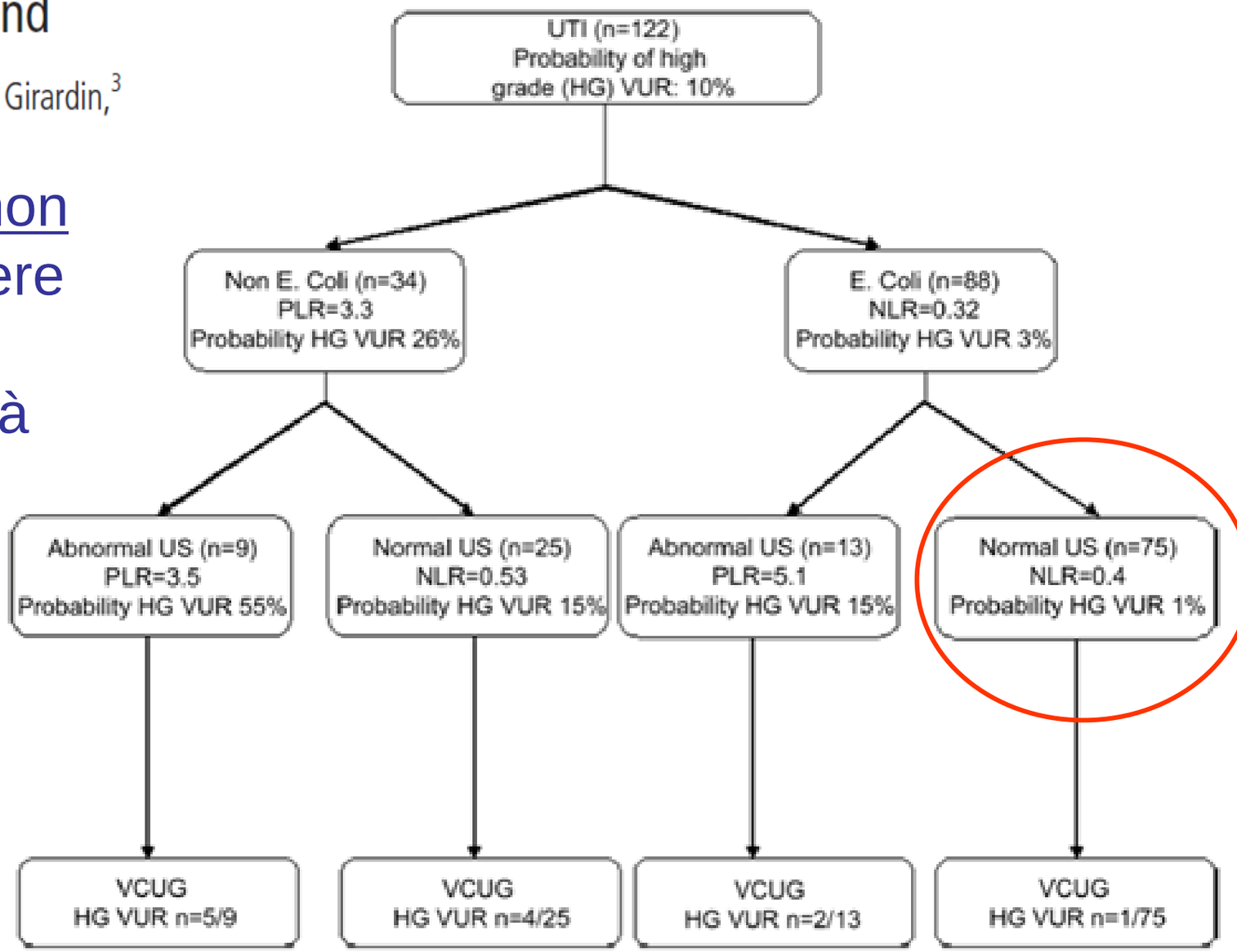
	NICE[3 6] <6 months	AAP[2] 2–24 months	Italy[4] 2–36 months	Switzerland[8] 0–16 years	France[5] 0–16 years
Renal US	All*	All†	– Atypical or recurrent UTI – Male infants <6 months	All†	All†
VCUG	– Abnormal renal US – Atypical or recurrent UTI	– Abnormal renal US – Atypical or recurrent UTI – Complex clinical circumstances	– Abnormal renal US	– Abnormal renal US – ≤3 months – Recurrent UTI – Family history of VUR	– Abnormal renal US – Bladder dysfunction in male

Avoidance of voiding cystourethrography in infants younger than 3 months with *Escherichia coli* urinary tract infection and normal renal ultrasound

Jean-Yves Pauchard,[1] Hassib Chehade,[2] Chafika Zohra Kies,[1] Eric Girardin,[3]

La presenza di una infezione non da *E. coli* è in grado di prevedere un RVU di alto grado con una sensibilità del 75% e specificità del 77%

Riduzione CUM del 62%, con un rischio molto basso (1%) di misconoscere un RVU di alto grado.



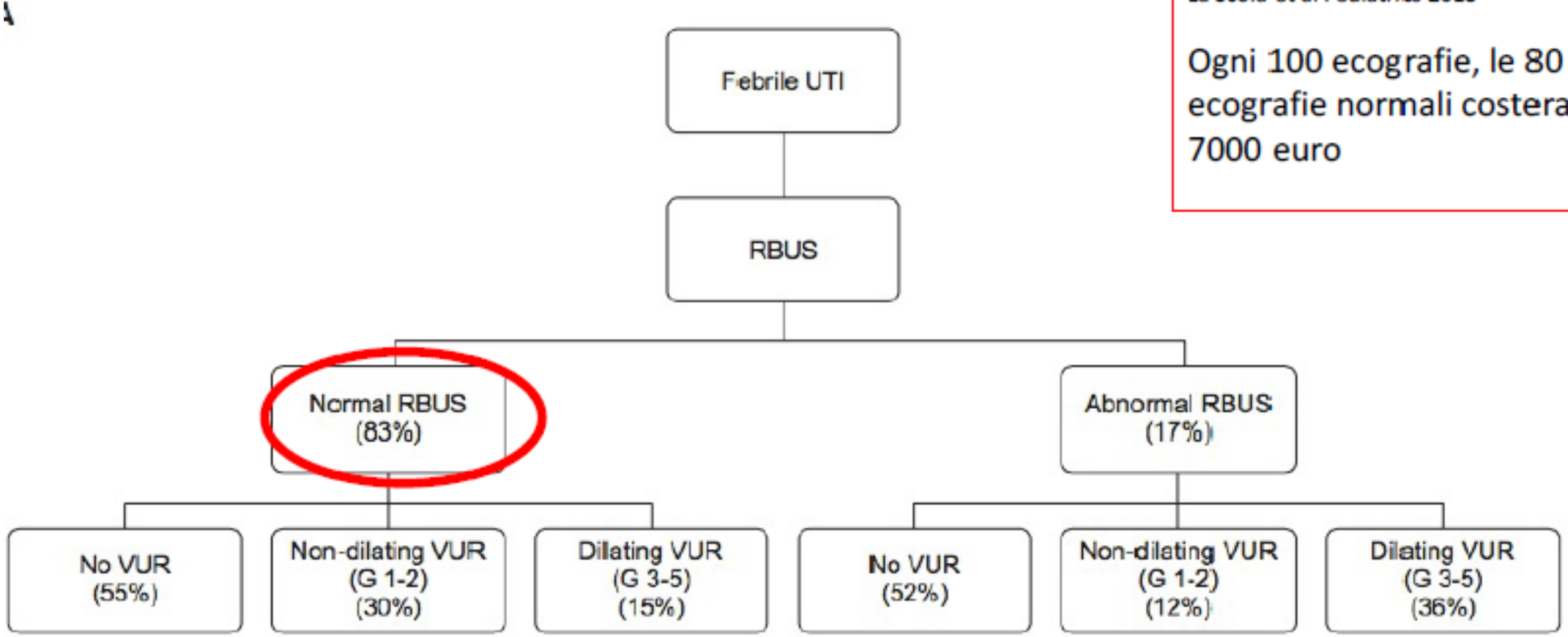
RISK FACTOR	FREQ	217 children at risk with VCUG						
		UNIVARIATE ANALYSIS				MULTIVARIATE ANALYSIS		
		High grade VUR (%)	OR	CI 95%	p-value	OR	CI 95%	p-value
US abnormalities	155 (71%)	60 (39%)	1.32	0.71-2.47	0.374	1.52	0.75-3.07	0.236
Abnormal prenatal US	38 (17%)	17 (45%)	1.49	0.73-3.02	0.270	1.26	0.59-2.70	0.537
Male <6 months	105 (48%)	36 (34%)	0.80	0.46-1.40	0.446	0.96	0.53-1.72	0.893
Pathogens other than *E.coli*	50 (23%)	27(54%)	2.52	1.32-4.81	0.005	2.74	1.39-5.41	0.003

Critical appraisal of the top-down approach for vesicoureteral reflux
Ahmed Abdelhalim, Antoine E. Khoury
Investig Clin Urol 2017;58 Suppl 1:S14-22.

Costs:
Renal ultrasonography: €82

La Scola et al Pediatrics 2013

Ogni 100 ecografie, le 80 ecografie normali costeranno circa 7000 euro



UTI febbrile

Urinocoltura

Non E. Coli

Ecografia

Patologica

Cistografia

Normale

E. Coli

Recidiva


Quello che cerchi è dentro di te.
Altrimenti è nel frigo...

Research

Original Investigation

Effect of Dilute Apple Juice and Preferred Fluids vs Electrolyte Maintenance Solution on Treatment Failure Among Children With Mild Gastroenteritis
A Randomized Clinical Trial

Stephen B. Freedman, MDCM, MSc; Andrew R. Willan, PhD; Kathy Boutis, MD; Suzanne Schuh, MD

JAMA. 2016;315(18):1966-1974. doi:10.1001/jama.2016.5352
Published online April 30, 2016.

Stesso patogeno, stesso bambino, stesso setting ?

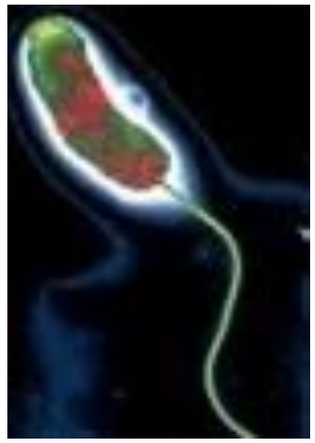
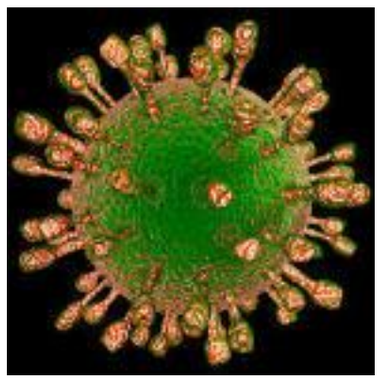


Figure 201-2 A child, lying on a cholera cot, showing typical signs of severe dehydration from cholera. The patient has sunken eyes, lethargic appearance, and poor skin turgor, but within 2 hr was sitting up, alert, and eating normally. *(From Sack DA, Sack RB, Nair GB, et al: Cholera.* Lancet *363:223–233, 2004.)*

ure 201-1 Rice water stool in a patient with cholera. *(Modifie*
n Harris JB, LaRocque RC, Qadri F: Cholera. Lancet *379:2466–2474*

Cholera gravis, the most severe form of the disease, results when purging rates of 500-1,000 mL/hr occur. This purging leads to dehydra-



se diluito 50 gr zucchero/ L

destrosio 20 gr/L , 45 mEq/L Na , 370 mg/L saccarosio

Figure 1. Screening, Randomization, and Follow-up

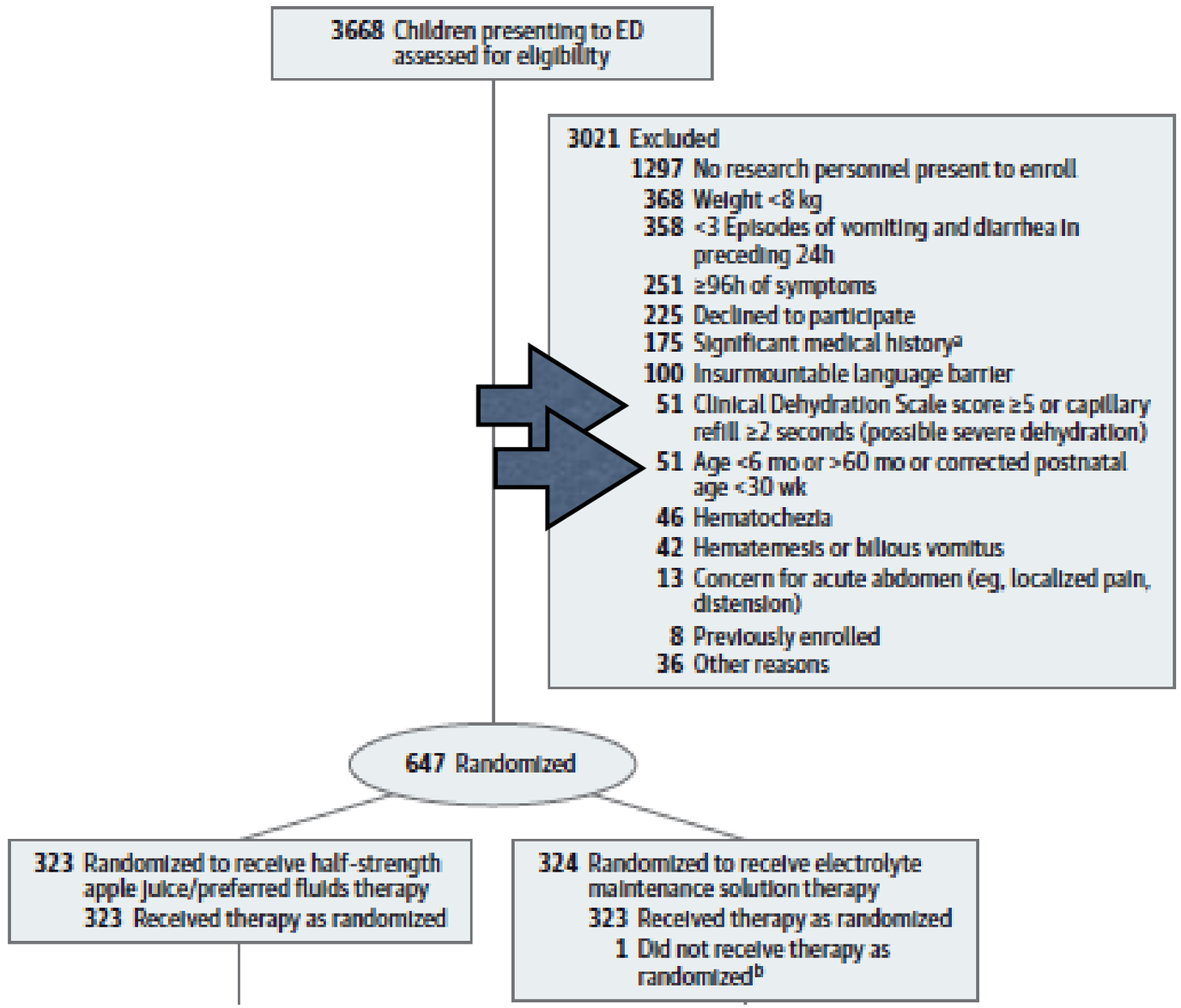


Table 1. Baseline Characteristics of the Randomized Treatment Groups

Characteristics	All Patients (n = 647)	Half-Strength Apple Juice/Preferred Fluids Therapy (n = 323)	Electrolyte Maintenance Solution Therapy (n = 324)
Age, mean (SD), mo	28.3 (15.9)	28.0 (15.4)	29.0 (16.5)
Male sex, No. (%)	331 (51.1)	173 (53.6)	158 (48.8)
Weight, mean (SD), kg	14.8 (11.4)	14.9 (12.1)	14.6 (10.2)
Enrollment time, mean (SD), 24-h clock	15:26 (3:27)	15:20 (3:35)	15:32 (3:18)
History of vomiting, No. (%)	610 (94.3)	306 (94.7)	304 (93.8)
Time interval between vomit onset and ED visit, mean (SD), h[a]	30.7 (22.8)	30.9 (22.9)	30.5 (22.7)
Vomiting episodes in preceding 24 h, median (IQR)[a]	5 (3-7)	5 (3-7)	5 (3-6)
History of diarrhea, No. (%)	274 (42.4)	136 (42.1)	138 (42.6)
Time interval between diarrhea onset and ED visit, mean (SD), h	36.6 (25.9)	36.1 (25.2)	37.1 (26.7)
Diarrhea episodes in preceding 24 h, median (IQR)[a]	3 (2-6)	3 (2-6)	3 (2-6)
Rotavirus vaccine received, No. (%)[b]	182 (28.1)	93 (28.8)	89 (27.5)
Baseline Clinical Dehydration Scale score, median (IQR)[c]	0 (0-1)	0 (0-1)	0 (0-1)
Baseline Clinical Dehydration Scale score distribution, No. (%)[c]			

Meglio reidratazione “a scelta”

Table 2. Composite Primary and Secondary Outcomes in the Study Groups[a]

Outcomes	Half-Strength Apple Juice/ Preferred Fluids Therapy		Electrolyte Maintenance Solution Therapy		Difference, % (95% CI)	*P* Value
	No./Total	% (95% CI)	No./Total	% (95% CI)		
Composite primary outcome: overall treatment failure, any criteria[b]	54/323	16.7 (12.8-21.2)	81/324	25.0 (20.4-30.1)	−8.3 (−∞ to −2.0)[c]	<.001[d]
Weight loss/dehydration at follow-up 72-84 h after index visit[g]	2/10	20.0 (2.5-55.6)	1/10	10.0 (0.3-44.5)	10.0 (−33.8 to 50.9)[e]	.99
IV rehydration[h]	8/323	2.5 (1.1-4.8)	29/324	9.0 (6.1-12.6)	−6.5 (−11.6 to −1.8)[e]	.001
Hospitalization	3/323	0.9 (0.2-2.7)	9/324	2.8 (1.3-5.2)	−1.9 (−5.4 to 1.3)[e]	.14

Treatment failure 16% vs 25%

Reidratazione ev 2.5% vs 9%


E poi arrivera' il momento
che ti sentirai forte,
fortissimo, in grado di
spaccare il mondo...
...ma niente...ti sarai gia'
messo il pigiama!

Parent-initiated oral corticosteroid therapy

- Una singola dose di prednisone (2 mgr/kg) all'inizio di un episodio di asma è associata ad un aumento delle visite di urgenza per asma.

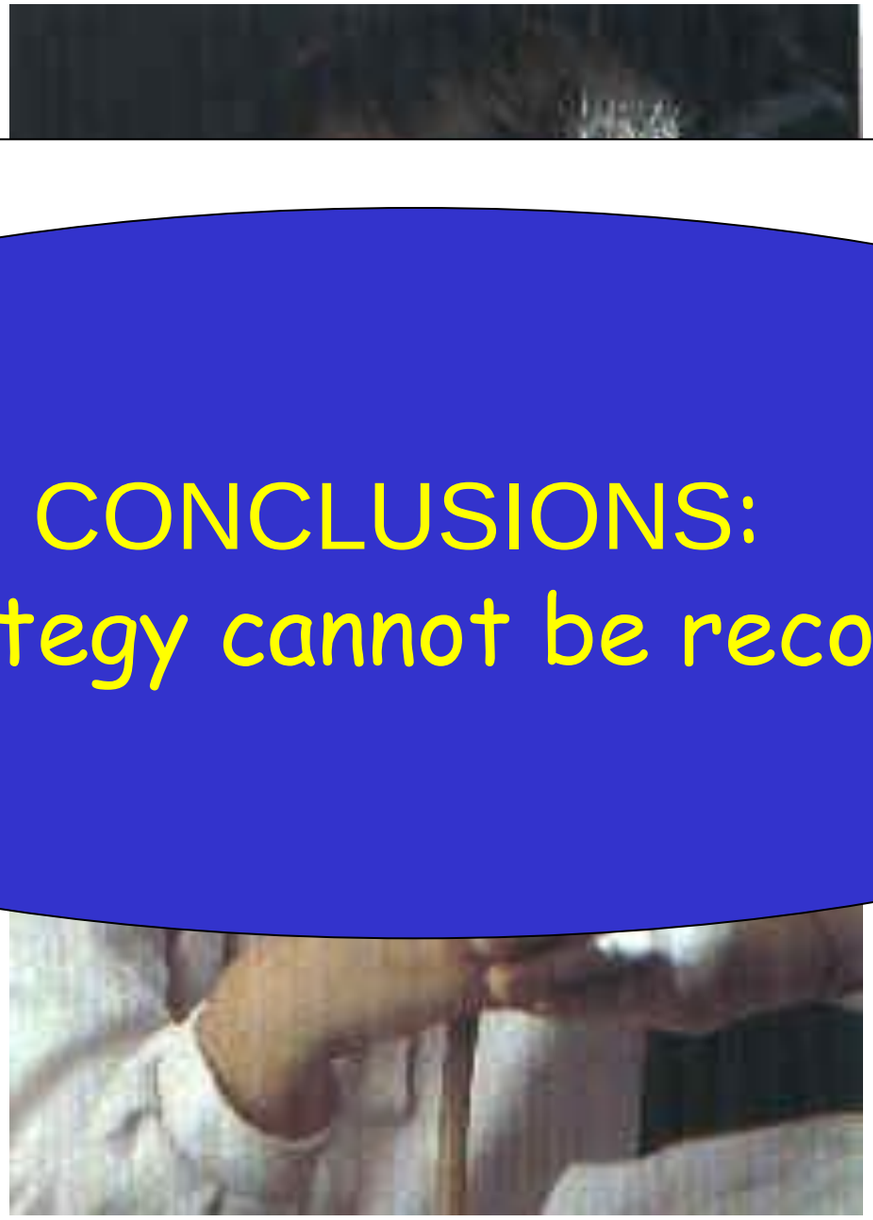
  Grant CC, Pediatrics. 1995

- 20 mgr di prednisone per 5 giorni non portano ad alcun beneficio, nemmeno nei soggetti che presentano un elevato numero di eosinofili

  Oommen A, Lancet. 2003

Parent-initiated oral corticosteroid therapy for intermittent wheezing illnesses in children.

Vuillermin P. Cochrane Database Syst Rev. 2006 Jul 19;3:CD005311



RISUL

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parere der

CONCLUSIONS:

"...this strategy cannot be recommended"

Eur Respir J 2008; 32: 1096–1110
DOI: 10.1183/09031936.00002108

Parent-initiated treatment with a short course of oral corticosteroide should not be given

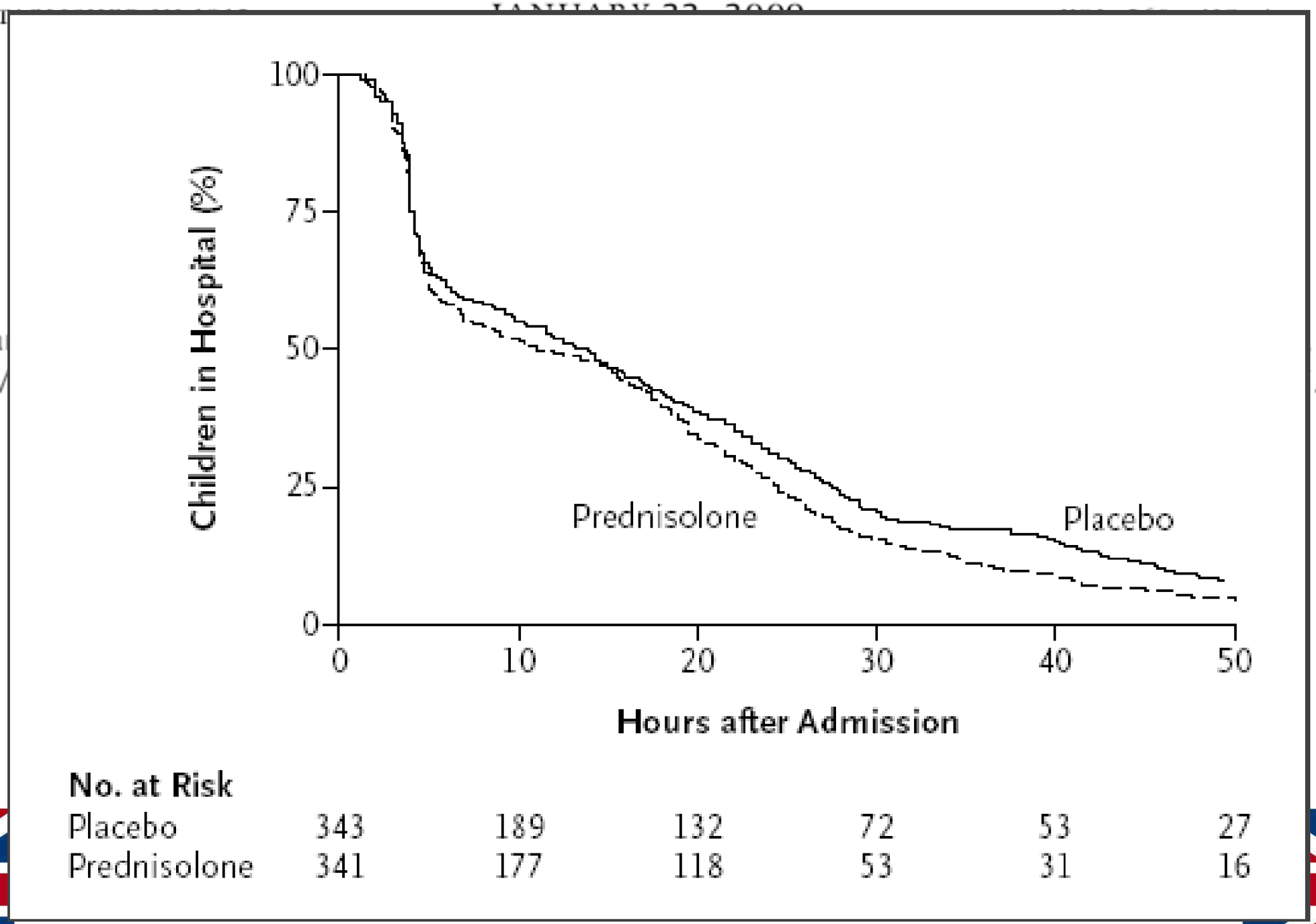
De
wheezing disorders
an evid

A trial of oral corticosteroids should probably be given to preschool children with acute wheeze of such severity that need to be admitted to hospital

The NEW ENGLAND JOURNAL of MEDICINE

EST[illegible] JANUARY 22, 2009

Jayachandra[illegible], Ph.D.,
Priti Kenia, M[illegible].P.C.H.,



No. at Risk

Placebo	343	189	132	72	53	27
Prednisolone	341	177	118	53	31	16

ORIGINAL ARTICLE

Parent-initiated oral corticosteroid therapy for intermittent wheezing illnesses in children: Systematic review

Peter J Vuillermin,[1,2,3] Colin F Robertson[1,2,4] and Mike South[1,2,5]

[1]Murdoch Children's Research Institute, [2]Department of Paediatrics, University of Melbourne, Departments of [4]Respiratory Medicine and [5]General Medicine, The Royal Children's Hospital, Melbourne and [3]Department of Clinical and Biomedical Sciences, Barwon Health, University of Melbourne, Geelong, Victoria, Australia

Pediatric Pulmonology 51:868–876 (2016)

Provare a dare il cortisone per via orale nel viral wheezing di gravità tale da richiedere l'accesso in ospedale può essere fatta, ma non è raccomandato che i genitori lo diano a casa

Jose A. Castro-Rodriguez, MD, PhD,[1]* Andrea A. Beckhaus, MD,[1] and Erick Forno, MD[2]

Definition, assessment and treatment of wheezing disorders in preschool children: an evidence-based approach

P.L.P. Brand, E. Baraldi, H. Bisgaard, A.L. Boner, J.A. Castro-Rodriguez, A. Custovic, J. de Blic, J.C. de Jongste, E. Eber, M.L. Everard, U. Frey, M. Gappa, L. Garcia-Marcos, J. Grigg, W. Lenney, P. Le Souëf, S. McKenzie, P.J.F.M. Merkus, F. Midulla, J.Y. Paton, G. Piacentini, P. Pohunek, G.A. Rossi, P. Seddon, M. Silverman, P.D. Sly, S. Stick, A. Valiulis, W.M.C. van Aalderen, J.H. Wildhaber, G. Wennergren, N. Wilson, Z. Zivkovic and A. Bush

Non sono d’accordo!

“Nella mia esperienza ne ho apprezzato sempre l’efficacia….”

“sarà che in Italia noi usiamo il Betametasone e che 1-2 dosi sono meglio di 5 di Prednisone”

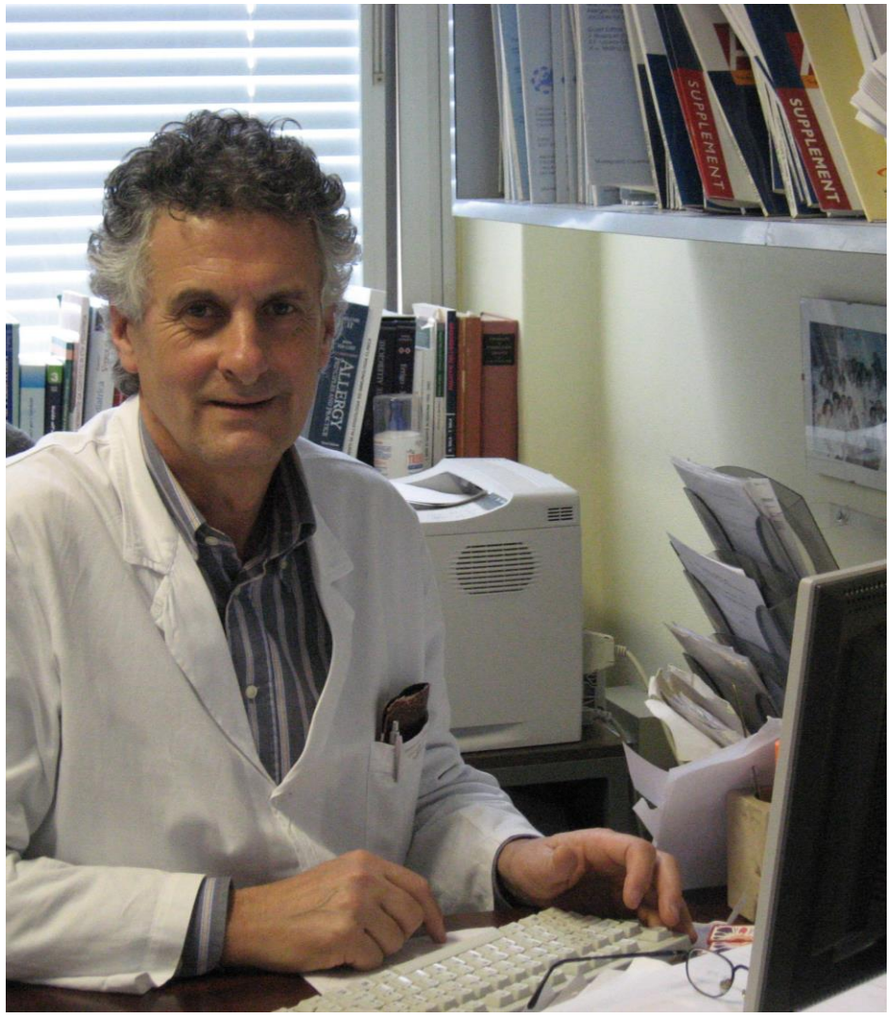
“il pdf conosce il bambino e il suo modo di presentare gli accessi“

“se un bambino ha già fatto più volte il Broncovaleas e si va verso sera…”

“di norma bastano singole dosi”

“una dose di Bentelan, non ha mai fatto male a nessuno! “

“risparmiare in coda, non in testa”

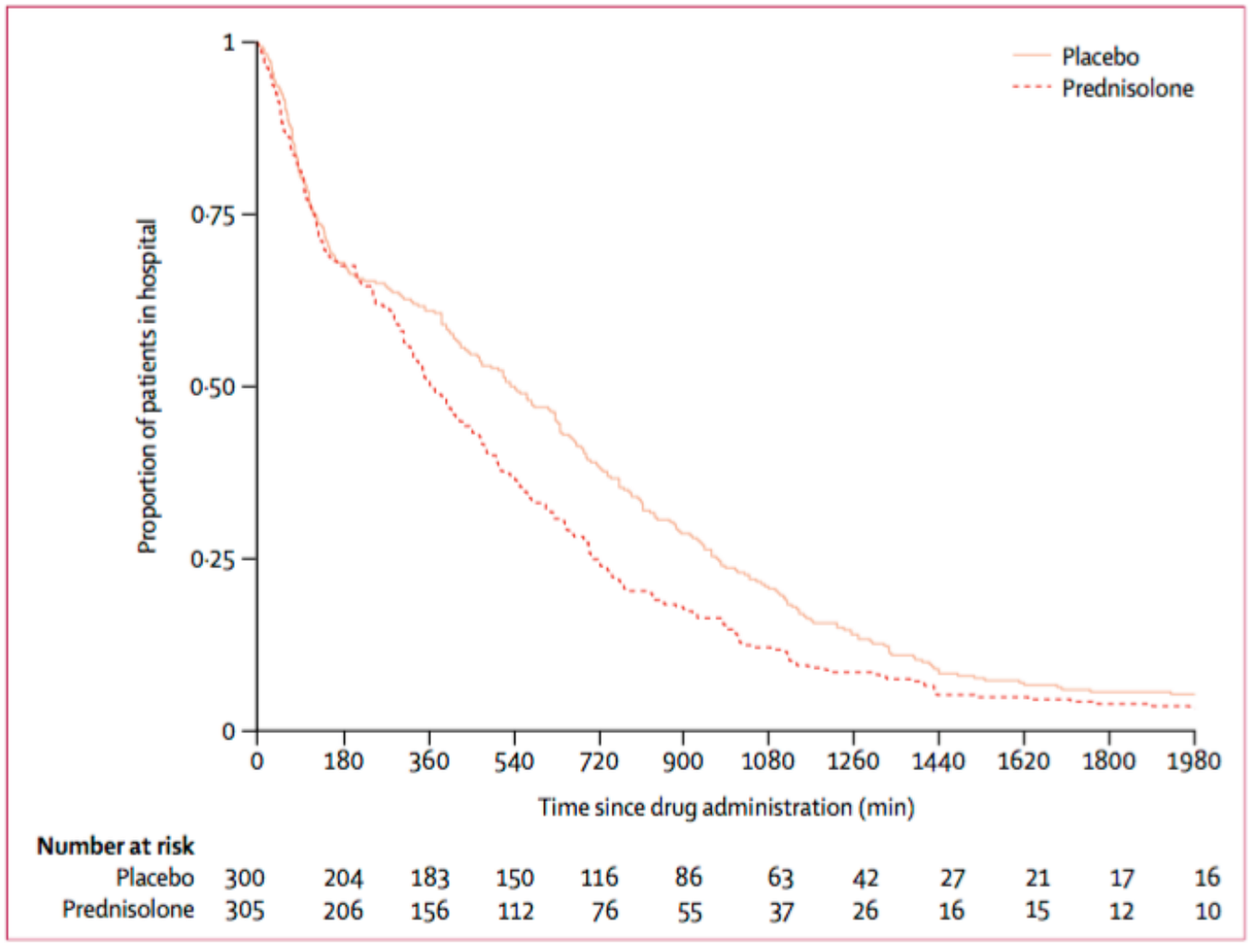


Oral prednisolone in preschool children with virus-associated wheeze: a prospective, randomised, double-blind, placebo-controlled trial

S J Foster, M N Cooper, S Oosterhof, M L Borland

624 bambini 24-72 mesi afferenti al PS Princess Magaret Hospital (Australia) per viral wheezing randomizzati a ricevere il Prednisolone (1 mg/Kg/die per 3 giorni) per bocca o il placeo

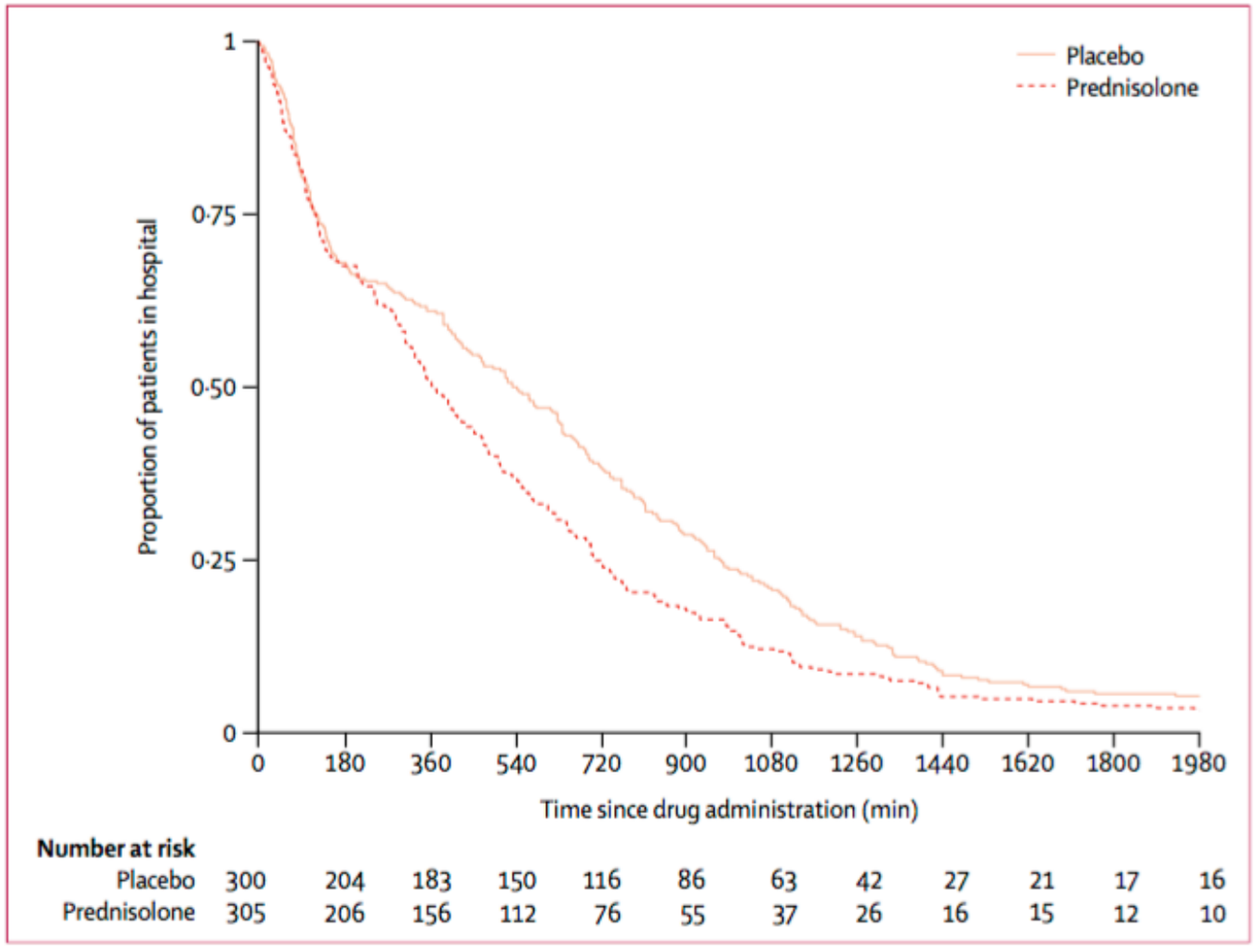
Somministrazione di Prednisone (o placebo) subito al triage



Oral prednisolone in preschool children with virus-associated wheeze: a prospective, randomised, double-blind, placebo-controlled trial

S J Foster, M N Cooper, S Oosterhof, M L Borland

- Il cortisone orale non agisce subito (nelle prime 3 ore non vi è alcuna differenza tra i gruppi)
- l'efficacia del cortisone si è dimostrata evidente nei bambini con broncospasmo più grave e che già avevano usato senza sufficiente risultato il Salbutamolo a casa
- non vi sono state differenze di esito in rapporto alla costituzione atopica (familiare o personale) dei soggetti.



ORIGINAL ARTICLES

www.jpeds.com • THE JOURNAL OF PEDIATRICS

Randomized Trial of Dexamethasone Versus Prednisone for Children with Acute Asthma Exacerbations

Natalia Paniagua, PhD, MD[1], Rebeca Lopez, MD[1], Natalia Muñoz, MD[1], Miriam Tames, MD[1], Elisa Mojica, PhD, MD[1], Eunate Arana-Arri, PhD, MD[2], Santiago Mintegi, PhD, MD[1], and Javier Benito, PhD, MD[1]

Circa 600 bambini 1-14 anni con attacco asmatico acuto randomizzati a ricevere il desametasone (0,6 mg/kg/die per 2 giorni) vs prednisone (1 mg/kg/die per 5 giorni)

Table II. Primary outcome in all patients included in the study

Variables	Dexamethasone group (n = 281)	Prednisone group (n = 276)	*P*
Persistence of symptoms by PACT at day 7	159 (56.6%)	161 (58.3%)	ns
	95% CI (50.6%-62.6%)	95% CI (52.3%-64.2%)	
Persistent symptoms			
While sitting quietly	16 (5.7%)	24 (8.7%)	ns
With light activity	41 (14.6%)	44 (15.9%)	ns
With sports	75 (26.7%)	91 (33%)	ns
While asleep at night	127 (45.2%)	123 (44.6%)	ns
In the morning	30 (10.7%)	34 (12.3%)	ns
Need of bronchodilator	242 (86.1%)	252 (91.3%)	ns
ARQoL at day 7*	80.0 (16.8)	77.7 (18.5)	ns

*Values are expressed as mean ± SD.

To conclude, two doses of dexamethasone were not inferior to a 5-day course of prednisone/prednisolone in children with mild-to-moderate asthma exacerbation treated in the ED setting. Therefore, this adds evidence for the use of dexa-

Safety Profile of Frequent Short Courses of Oral Glucocorticoids in Acute Pediatric Asthma: Impact on Bone Metabolism, Bone Density, and Adrenal Function

Francine M. Ducharme, Gilles Chabot, Constantin Polychronakos, Francis Glorieux

CONCLUSIONS:

Repeated short courses of oral glucocorticoids in the treatment of asthma was not associated with any lasting perturbation in bone metabolism, bone mineralization, or adrenal function.

- Metabolismo osseo
- Funzionalità surrenalica

Pediatrics 2003;111:376–383;

ACTA PÆDIATRICA
NURTURING THE CHILD

Randomised comparison of intravenous magnesium sulphate, terbutaline and aminophylline for children with acute severe asthma

Sunit Singhi (sunit.singhi@gmail.com), Sudhanshu Grover, Arun Bansal, Kapil Chopra
Department of Pediatrics, Advanced Pediatrics Centre, Postgraduate Institute of Medical Education and Research, Chandigarh, India

2014

RCT su 100 bambini (1-18 aa)

salbutamolo inal + ipratropio ogni 20'+ idrocortisone

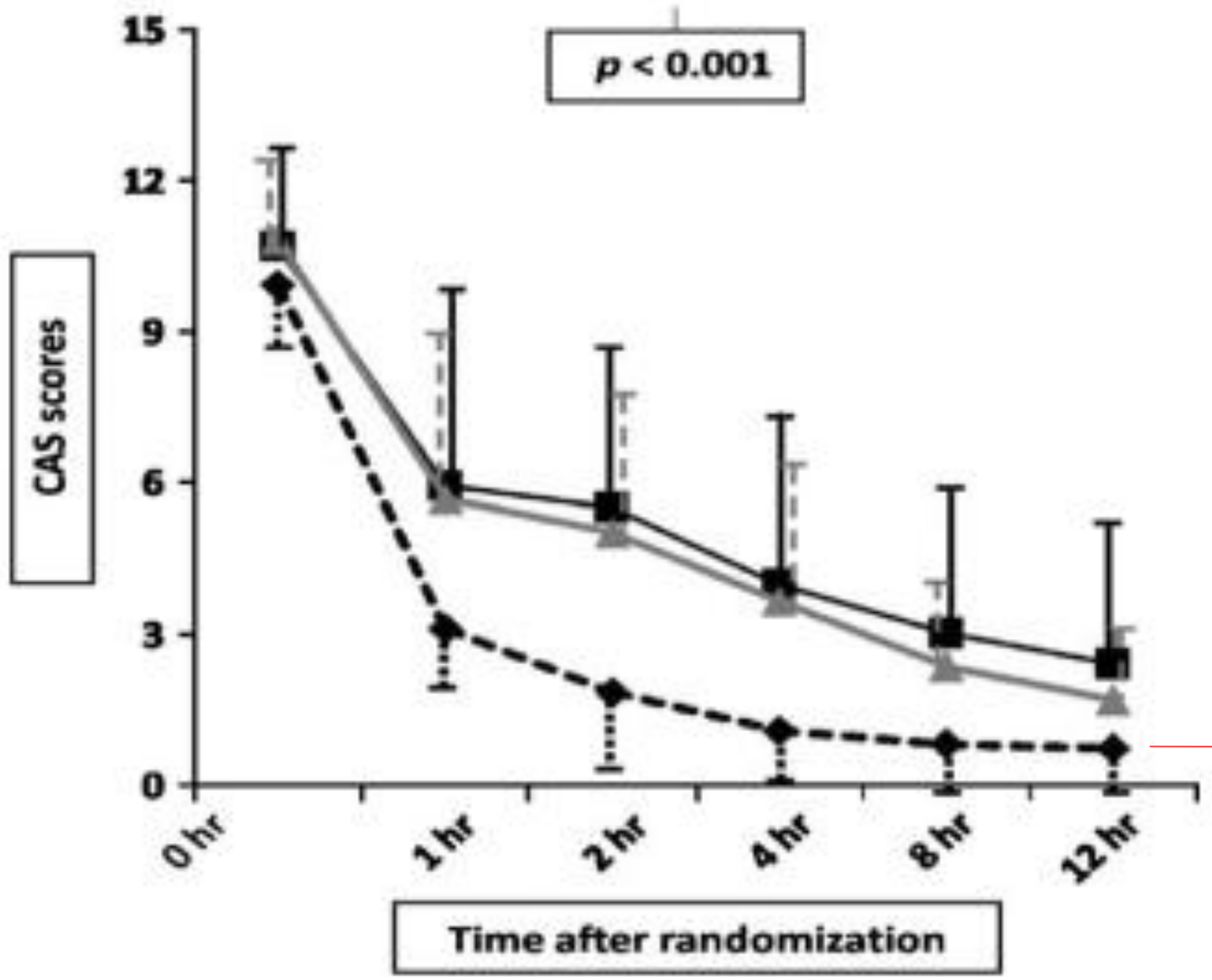
34 pz MgSolfato 50 mg/kg in 20'

33 pz Terbutalina 10 mcg/kg in bolo + 0.1 mcg/kg/min fino 1 mcg/kg/min

33 pz Aminofillina 5 mg/kg + 0.9 mg/kg/h

OC1: miglioramento CAS di 4 punti in 1 ora
OC2: andamento dello score in 12 ore ed eventuali reazioni avverse

ACTA PÆDIATRICA
NURTURING THE CHILD



MgSolfato

- nessun effetto collaterale (ipotensione) nel gruppo MgSolfato
- 2 bambini con ipocaliemia nel gruppo Terbutalina
- 9 bambini con vomito e dolore addominale nel gruppo Aminofillina


LA CALMA E' LA VIRTU'
DI CHI NON E' COINVOLTO.
SCHULZ

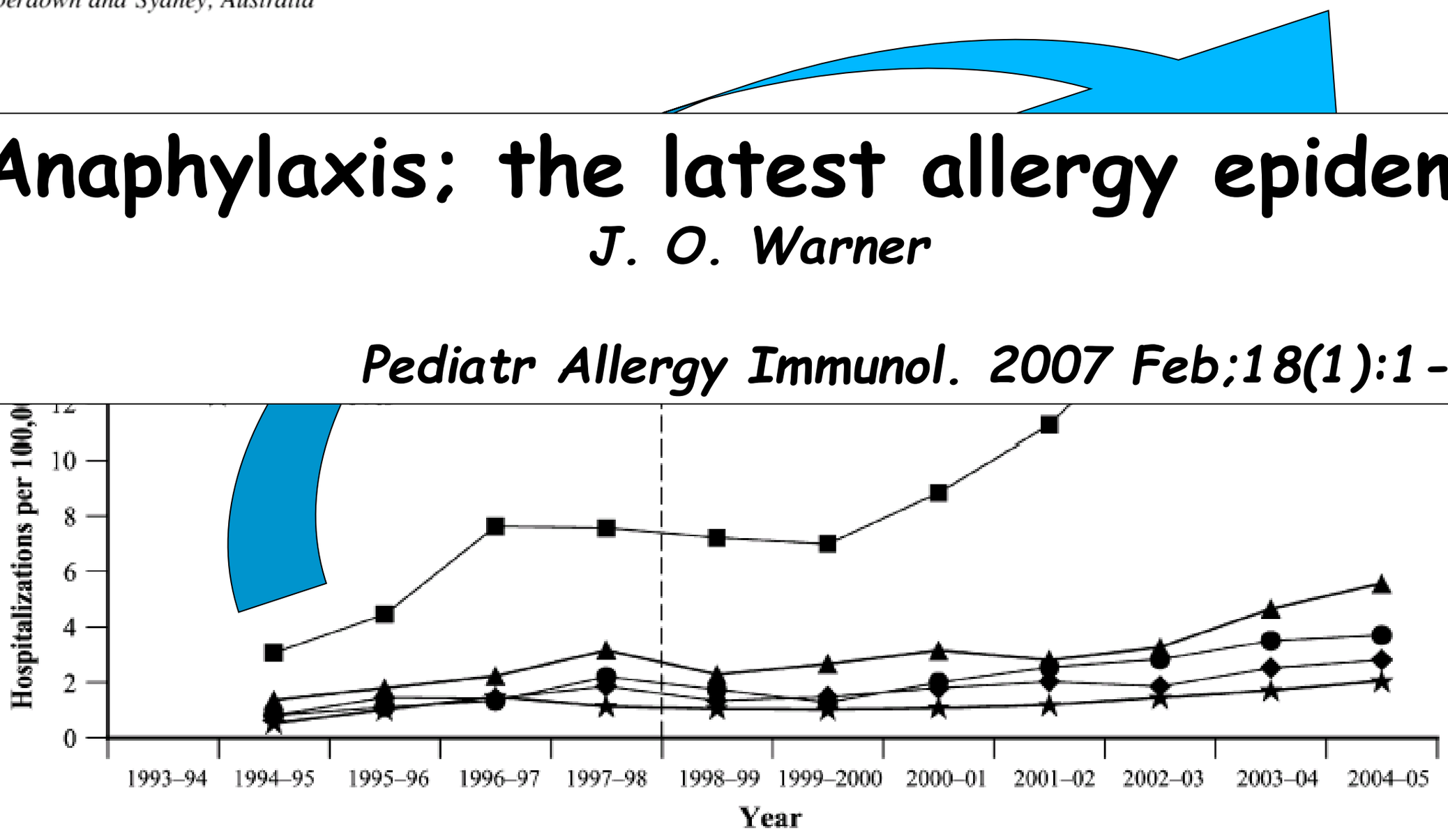
Trends in hospitalizations for anaphylaxis, angioedema, and urticaria in Australia, 1993-1994 to 2004-2005

Leanne M. Poulos, BMedSc (Hons),[a] Anne-Marie Waters, Grad Dip Pop Hlth,[a]
Patricia K. Correll, MPH,[a] Robert H. Loblay, PhD,[b] and Guy B. Marks, PhD[a]
Camperdown and Sydney, Australia

Anaphylaxis; the latest allergy epidemic

J. O. Warner

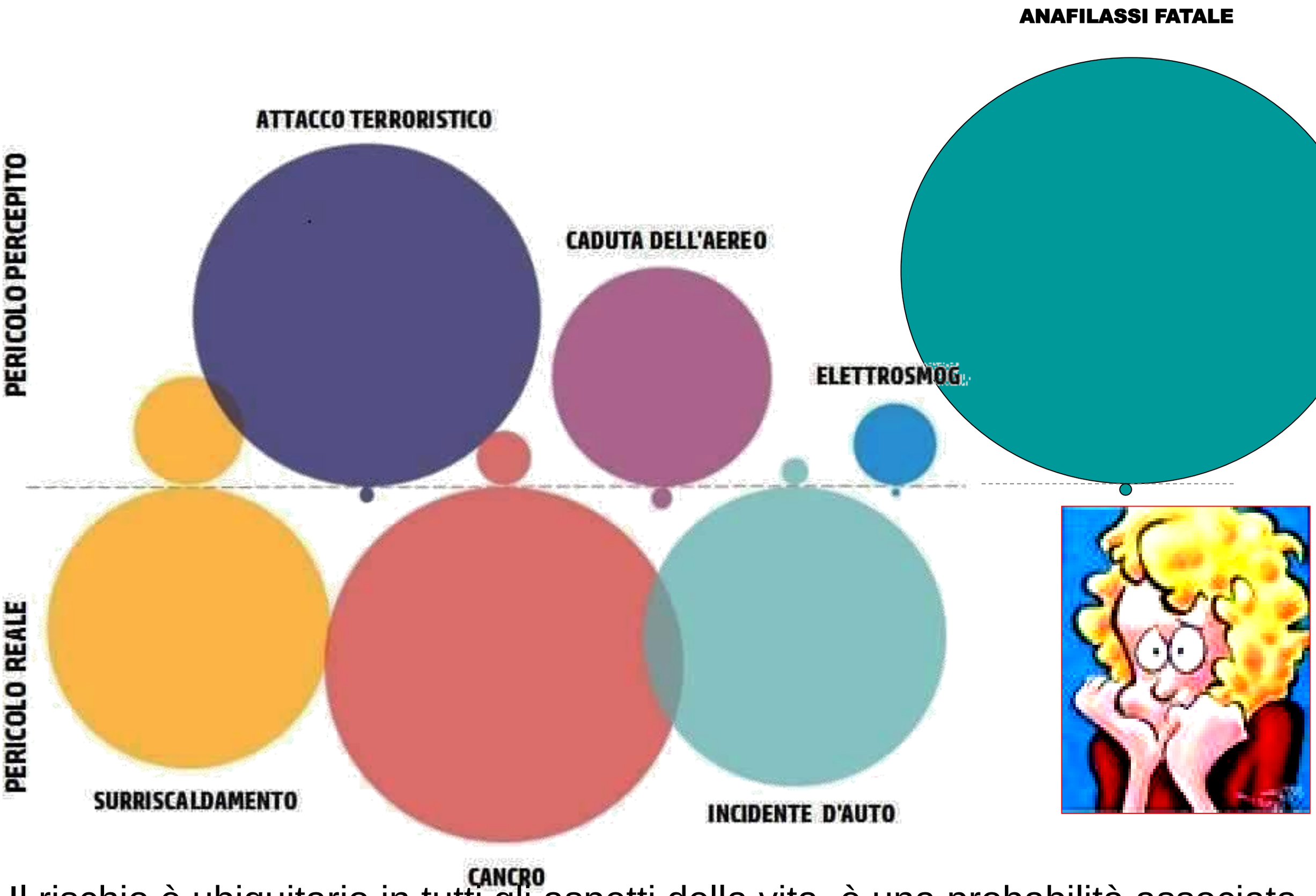
Pediatr Allergy Immunol. 2007 Feb;18(1):1-2



Hospitalization for anaphylaxis to food from 1995 to 2005 ia, 1994-1995 to

fake

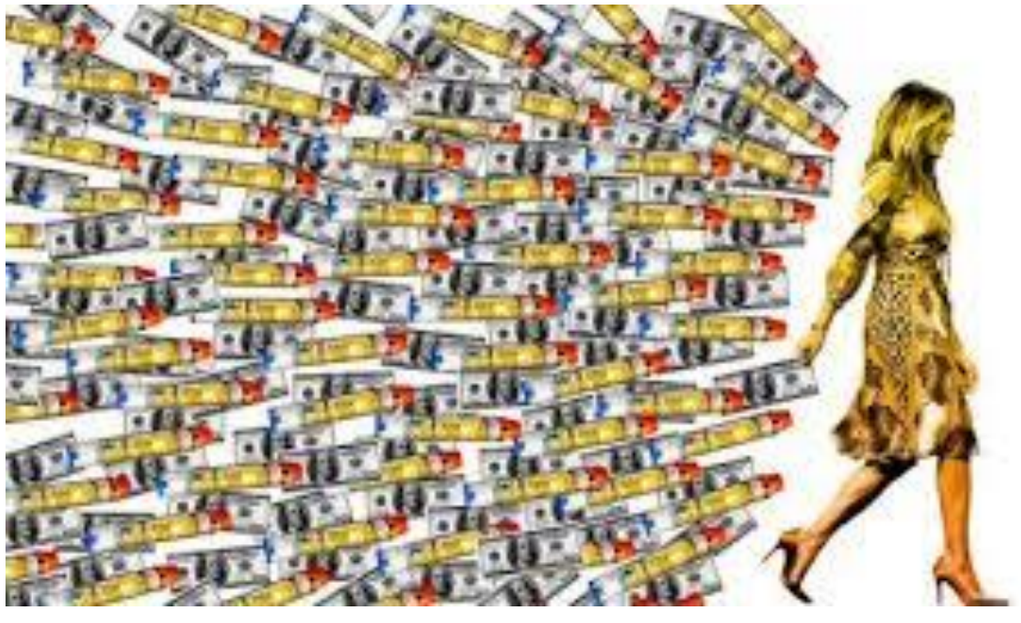

STOP
ANAPHYLAXIS
EAACI
BEHIND THE
SWEETEST MOMENTS
HIS LIFE MAY BE IN
IMMINENT
DANGER



Il rischio è ubiquitario in tutti gli aspetti della vita, è una probabilità associata con l'incertezza delle conseguenze, la cui percezione è diversa da individuo ad individuo

Crescente presenza di PAL (precautionary allergen labelling)
(“può contenere tracce di…” “lavorato in stabilimento che usa anche…”)

Crescente prescrizione di autoiniettori di Adrenalina



Rischio reazione allergica nei pazienti suscettibili di allergia alimentare

Esistono tanti scoring di gravità diversi e differenti definizioni di anafilassi in letteratura

Non viene mai presa in considerazione la quantità di allergene che ha causato la reazione

I sintomi allergici sono spesso sovra- (o sotto-) stimati dal paziente e dagli operatori sanitari con scarsa familiarità per le reazioni allergiche sistemiche

La valutazione del rischio nel' allergia alimentare include sia la proabilità che una reazione allergica si verifichi sia la gravità stessa della reazione

Fattori che influenzano la gravità delle reazioni

doi: 10.1111/cea.12211

Clinical & Experimental Allergy, **43**, 1333–1341

REVIEW

Incidence of fatal food anaphylaxis in people with food allergy: a systematic review and meta-analysis

T. Umasunthar[1,2], J. Leonardi-Bee[3], M. Hodes[2,4], P. J. Turner[1,2], C. Gore[1,2], P. Habibi[1,2], J. O. Warner[1,2] and R. J. Boyle[1,2]

[1]Department of Paediatrics, Imperial College London, London, UK, [2]Imperial College Healthcare NHS Trust, St Mary's Hospital, London, UK, [3]Division of Epidemiology and Public Health, University of Nottingham, Nottingham, UK and [4]Academic Unit of Child and Adolescent Psychiatry, Imperial College London, London, UK

L'anafilassi fatale nei soggetti con allergia IgE-mediata agli alimenti è più rara della morte accidentale nella popolazione generale

Title

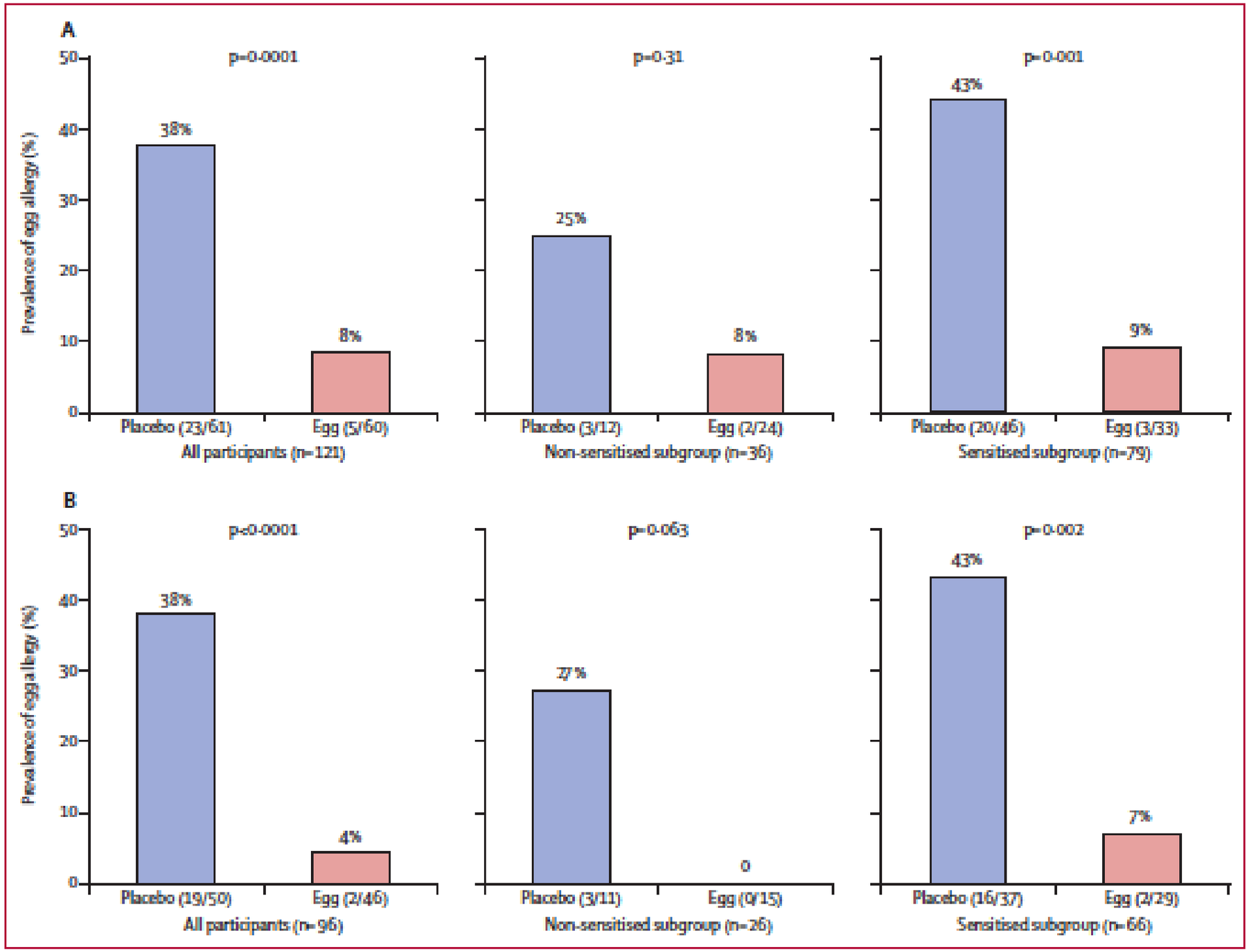
How does dose impact on the severity of food-induced allergic reactions, and can this improve risk assessment for allergenic foods?

Report from an ILSI Europe Food Allergy Task Force Expert Group and Workshop

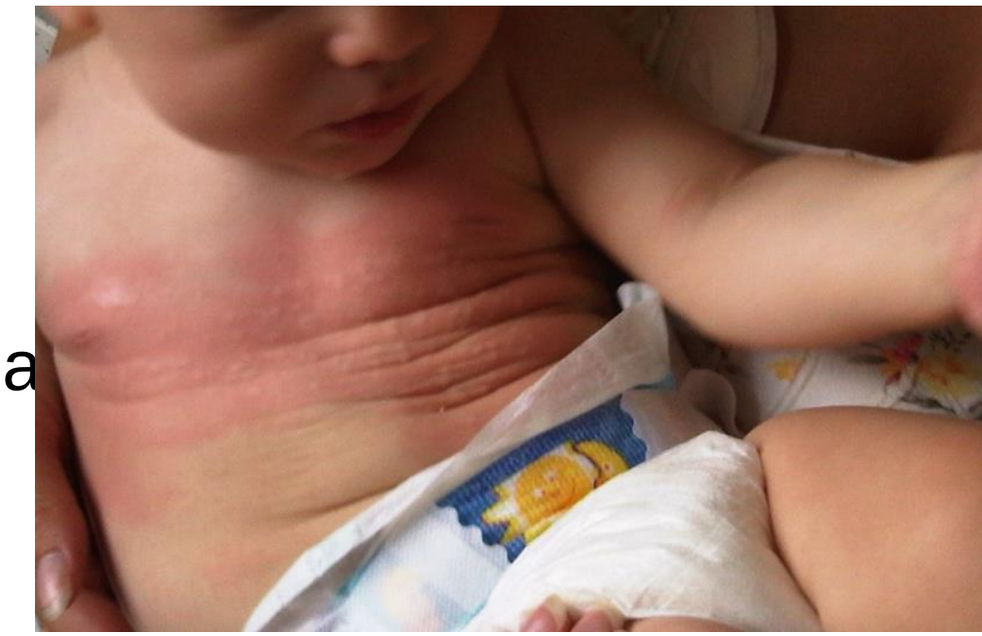
Vi è un urgente bisogno di demistificare le reazioni allergiche
indotte da alimenti ed educare alla consapevolezza
che la maggioranza delle reazioni IgE-mediate
non sono anafilattiche
né tanto meno “life-threatening”

Two-step egg introduction for prevention of egg allergy in high-risk infants with eczema (PETIT): a randomised, double-blind, placebo-controlled trial

121 nello studio, fermato dopo analisi dei primi 100 per la chiara differenza fra i due gruppi



Pamela, 5 mesi e mezzo



Sempre allattamento materno

Al 1° biberon di latte di formula sviluppa
ORTICARIA GENERALIZZATA

Entra nel progetto di
DESENSIBILIZZAZIONE PRECOCE

Assume 1, 5, 10 ml di latte
vaccino (in ambiente protetto)

A casa continua a assumere la massima dose tollerata e torna per i raddoppi in ambiente protetto

DOPO 4 MESI dall'inizio della desensibilizzazione Pamela mangia latte e latticini senza limitazioni

280 lattanti (latte e uovo).

249 dieta libera in 5-6 mesi.

Mangiando la sua prima minestrina con l'uovo:

orticaria diffusa, un vomito.
Ma sta benone.

La madre chiama il vecchio pediatra:

"un cucchiaino domani nella minestra, poi aumenti pian piano, ogni giorno"

Ancora qualche vomito ogni tanto, ma nulla più, finchè riesce a mangiarsi un uovo intero…e il tiramisù il giorno del suo primo compleanno.


Chi è senza peccato,
cerchi di ricordarsi
meglio .....

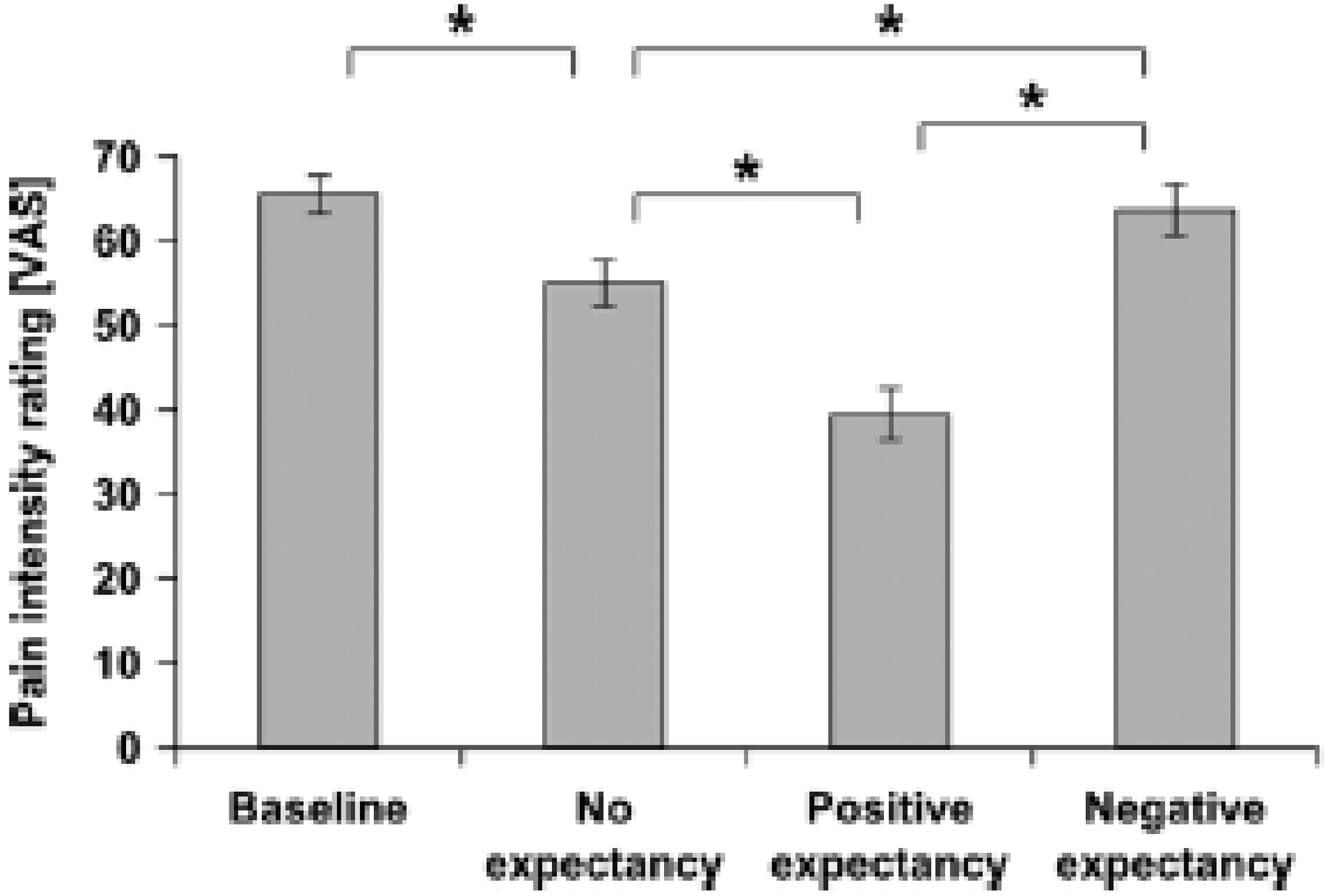
RESEARCH ARTICLE

DRUG EFFICACY

The Effect of Treatment Expectation on Drug Efficacy: Imaging the Analgesic Benefit of the Opioid Remifentanil

Ulrike Bingel,[1,2]* Vishvarani Wanigasekera,[1] Katja Wiech,[1] Roisin Ni Mhuircheartaigh,[1] Michael C. Lee,[3] Markus Ploner,[4] Irene Tracey[1]

le aspettative positive raddoppiano l'effetto benefico del remifentanil



aspettative negative aboliscono l'effetto benefico del remifentanil

placebo : corteccia prefrontale dorso-laterale, cingolata anteriore, striato, opercolo frontale: **dopamina , endorfine**

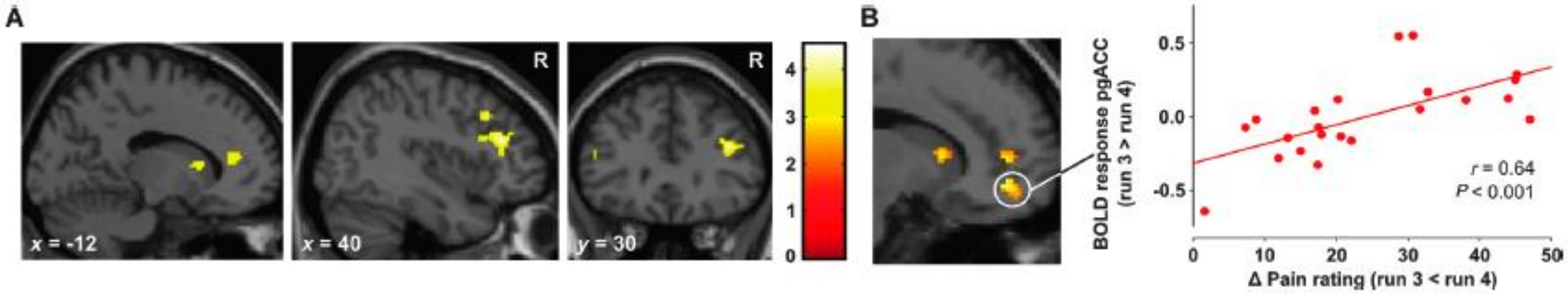


Fig. 6. Impaired analgesia during negative expectation is associated with hippocampal activity. (**A**) Pain-related BOLD responses during negative expectancy. The images are thresholded at $P < 0.005$ uncorrected for visualization purposes. Color bar indicates t score. Right: Scatter plot of the

nocebo : media-prefrontale, ippocampo e corteccia cingolata media : **colecistochinina.**

Paracetamolo: meccanismo azione

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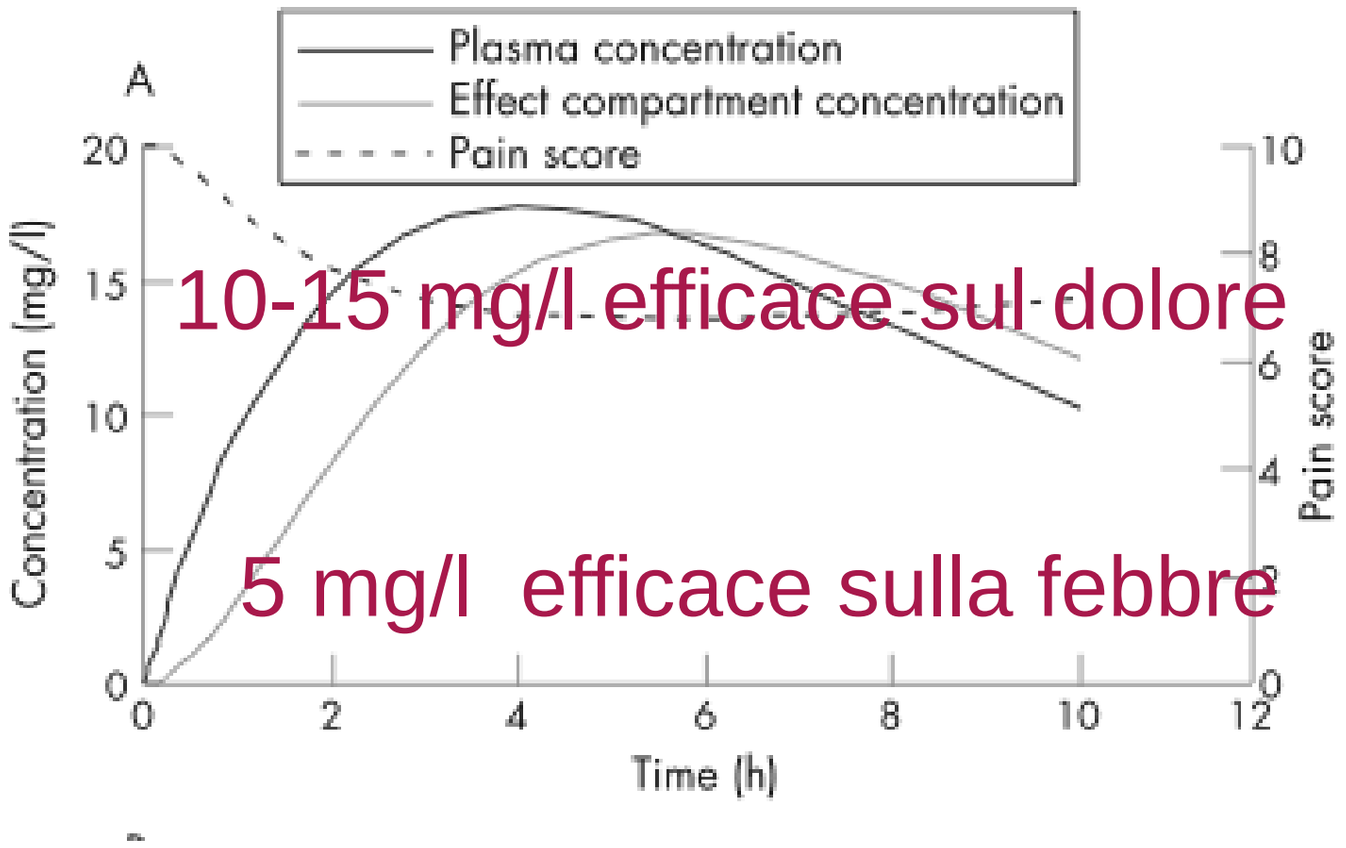
- inibizione ciclo-ossigenasi
- interazione col sistema oppioidi endogeni (via oppioide discendente e interazione sinergica a livello spinale)
- attivazione via serotoninergica bulbo-spinale discendente
- interazione sistema ossido nitrico e recettori NMDA
- aumento tono sistema cannabinoide/vanilloide (attivazione indiretta dei recettori cannabinoidi con aumento cannabinoidi endogeni : effetto antipiretico, benessere....)

niente male Junior

Paracetamol (acetaminophen) pharmacodynamics: interpreting the plasma concentration

I A Gibb,[1] B J Anderson[2]

Arch Dis Child 2008;**93**:241–247.



10-15 mg/l efficace sul dolore

5 mg/l efficace sulla febbre

Somministrazione di 12.5 mg/kg di sciroppo
Relazione tra concentrazione plasmatica, concentrazione compartimentale e analgesia

Paracetamolo

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Fattori di Rischio

- Maggior rischio di epatotossicità se :
  - Disidratazione
  - Malnutrizione
  - Digiuno prolungato
- Uso a dosaggio pieno per oltre 48-72 ore
- Uso di farmaci concomitanti (rifampicina, carbamazepina, fenobarbital, fenitoina, primidone, acido valproico, alcool)
- Epatopatia pre-esistente
- Miopatia e intervento chirurgico , obesità, diabete

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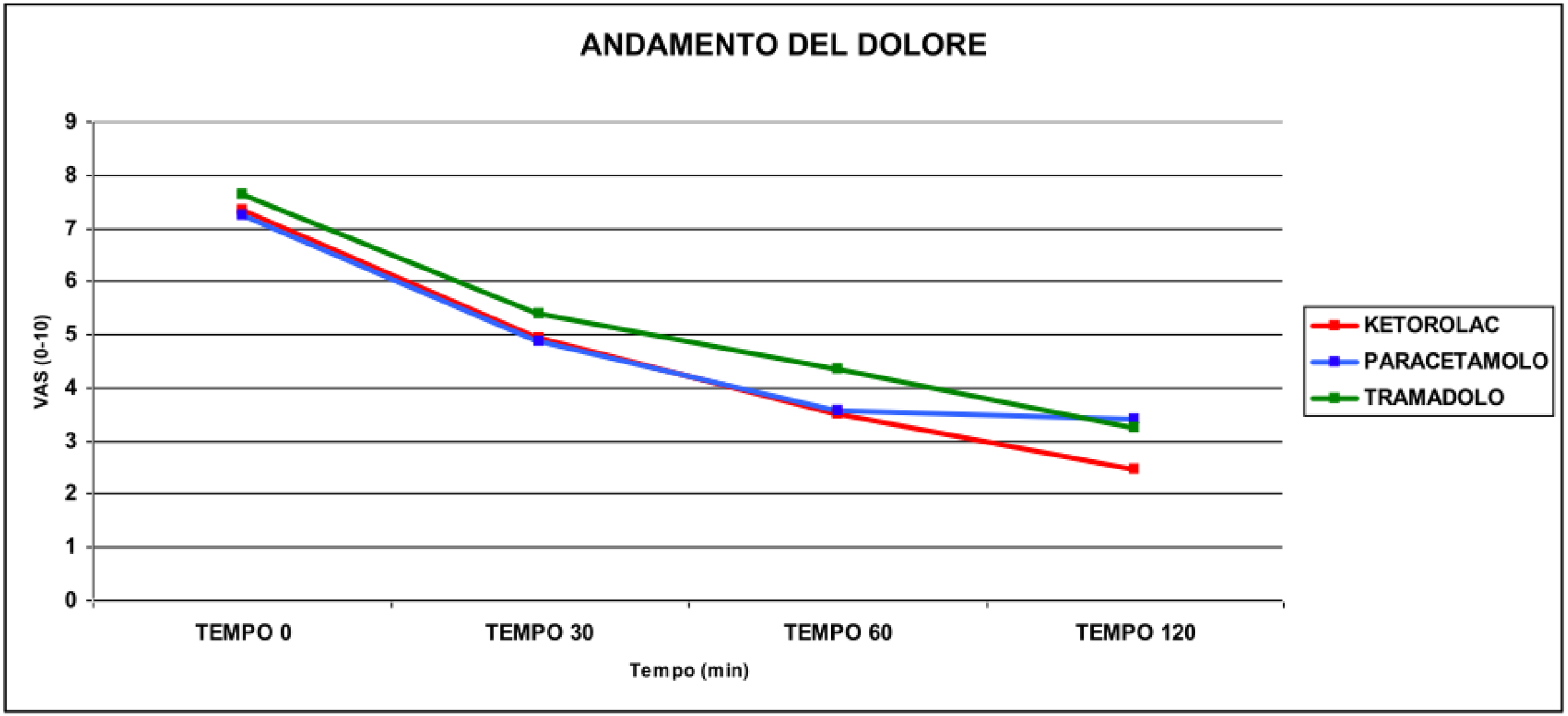
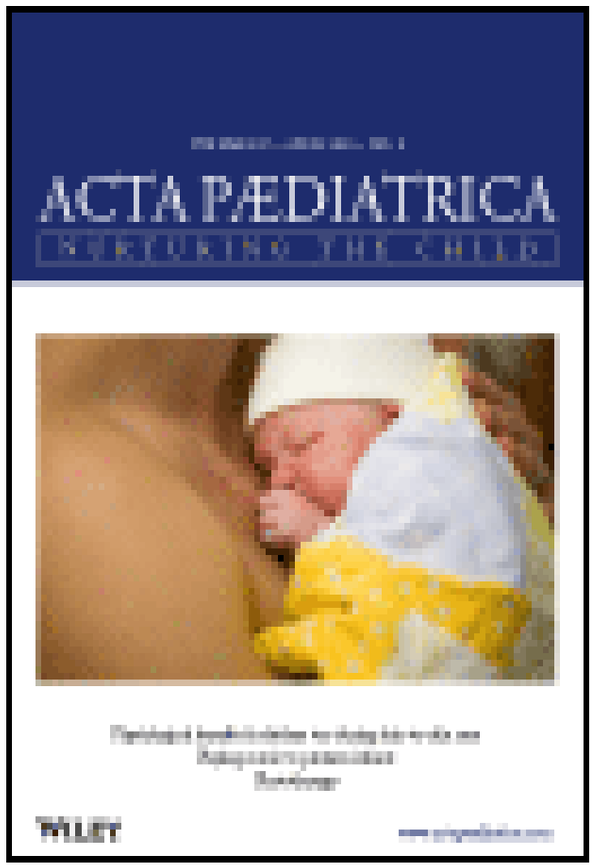
Dolore addominale acuto in PS : confronto tra 3 farmaci sublinguali .





Article type : Review Article

Narrative review shows that the short-term use of ketorolac is safe and effective in the management of moderate to severe pain in children

Pierluigi Marzuillo[1], Lorenzo Calligaris[2], Stefano Amoroso[3] and Egidio Barbi[2,3]

FDA Drug Safety Communication:

FDA restricts use of prescription codeine pain and cough medicines and tramadol pain medicines in children; recommends against use in breastfeeding women


pisko
buonanotte
Un giorno ci toccherà morire, Snoopy
Certo, Charlie, però gli altri giorni no
visto su facciabuco.com

Piramide della gerarchia dei bisogni .

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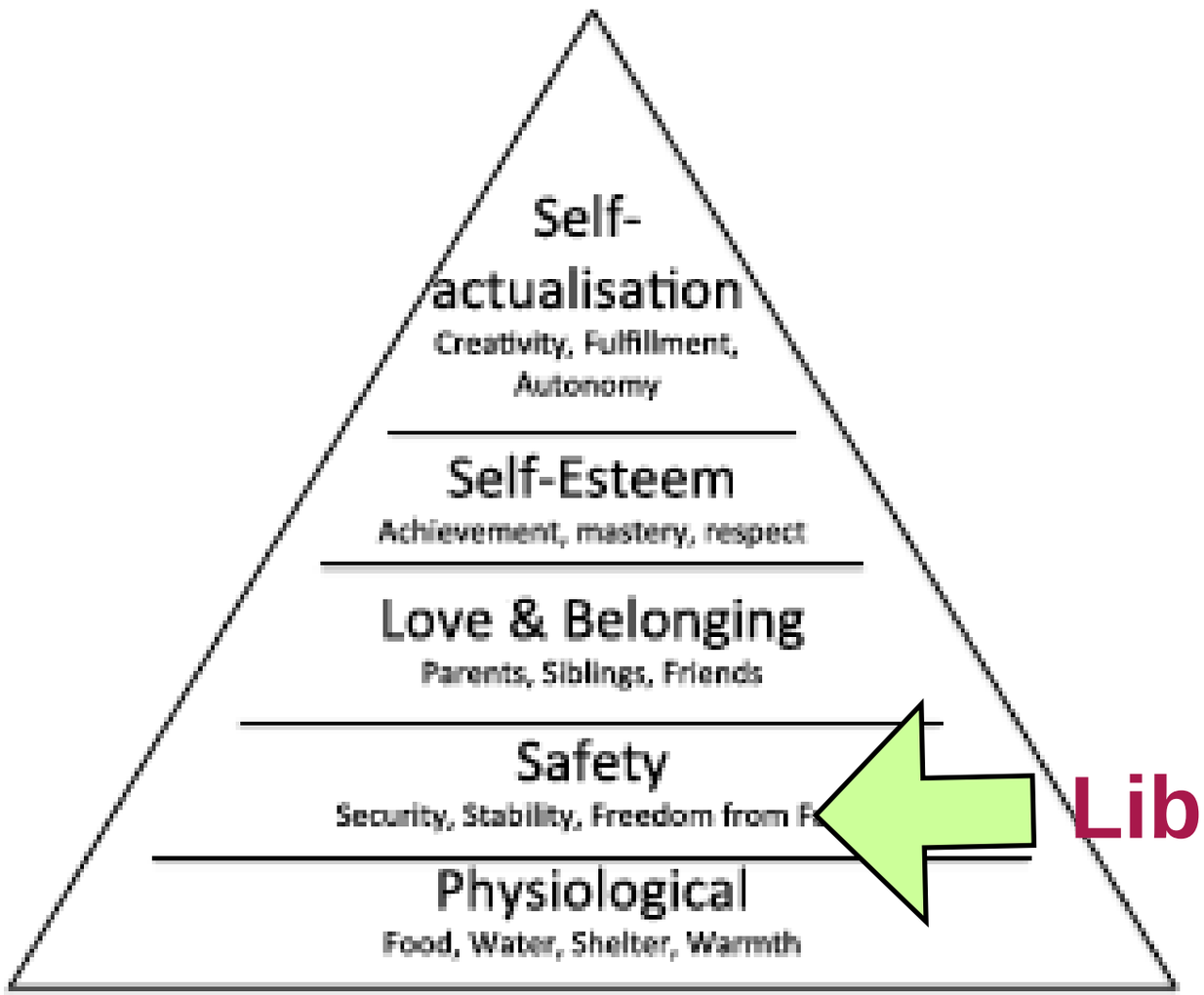
Figure 2: Maslow's Hierarchy of Needs (Maslow, 1954)



Libertà dal dolore

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1) conoscere le dimensioni del problema

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- frequenza di abuso 0-15 anni : 6 casi su 1000, di cui 30% abuso sessuale (2,5-6% dati più recenti)
- maltrattamento fisico : prevalentemente < 5 anni, max primi 3 anni (**16-20 per mille**)
- abuso sessuale picco a 4-6 anni

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LIVIDI-PREVALENZA
B. CHE NON CAMMINANO <1%
B. CHE CAMMINANO 50%

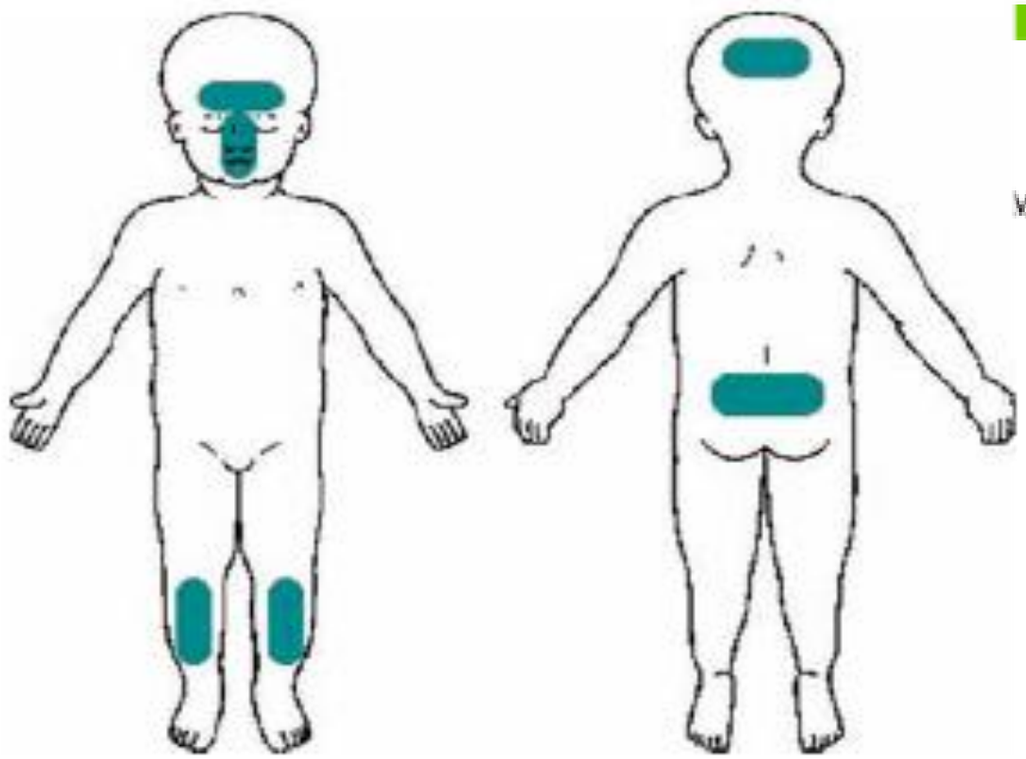

Figure 1 Accidental bruising patterns.

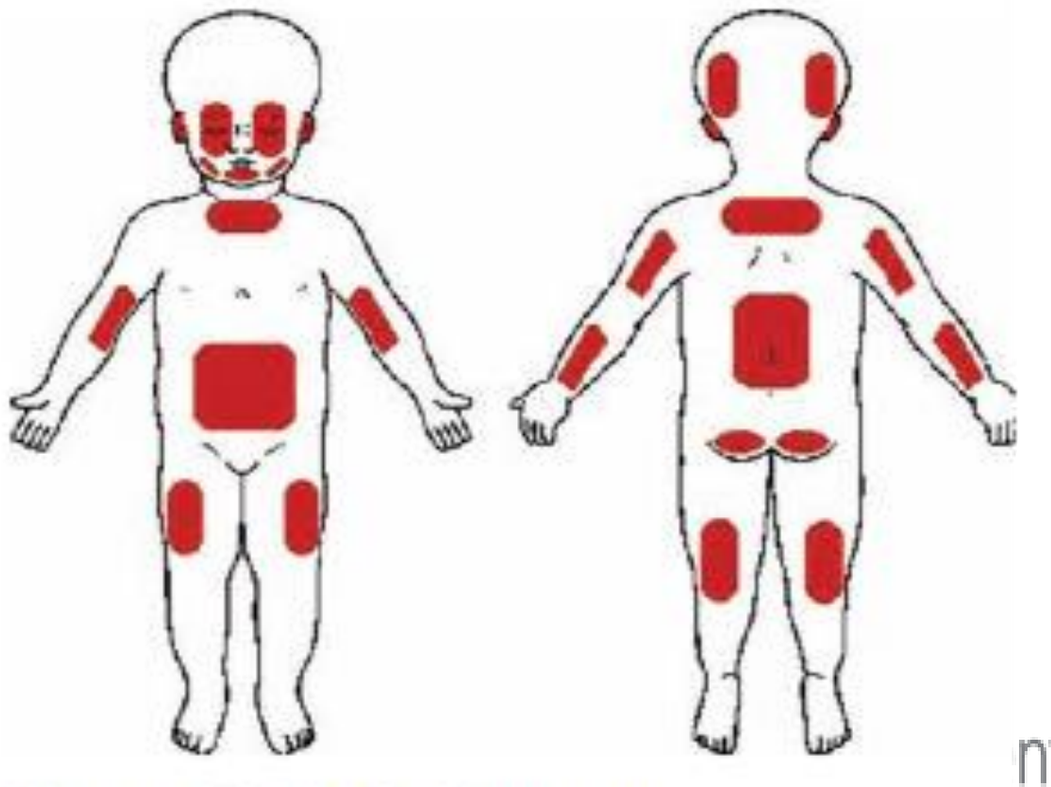

Figure 2 Abusive bruising patterns.

Lividi+ petecchie
(escluse coagulopatie)
Potere Predittivo Positivo
per maltrattamento
80%

THE JOURNAL OF PEDIATRICS • www.jpeds.com

ORIGINAL ARTICLES

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Additional Injuries in Young Infants with Concern for Abuse and Apparently Isolated Bruises

Nancy S. Harper, MD[1], Kenneth W. Feldman, MD[2], Naomi F. Sugar, MD[3,*], James D. Anderst, MD, MSCI[4], and Daniel M. Lindberg, MD[5,6], for the Examining Siblings To Recognize Abuse Investigators[†]

- 146 lattanti < 6 mesi con ecchimosi isolate
- 50% ha una lesione ulteriore
- 23% frattura
- 27% lesione al neuroimaging
- 2% lesione epatica con rialzo transaminasi

17

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USTIONI

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Figure 3 Accidental scald pattern.

173

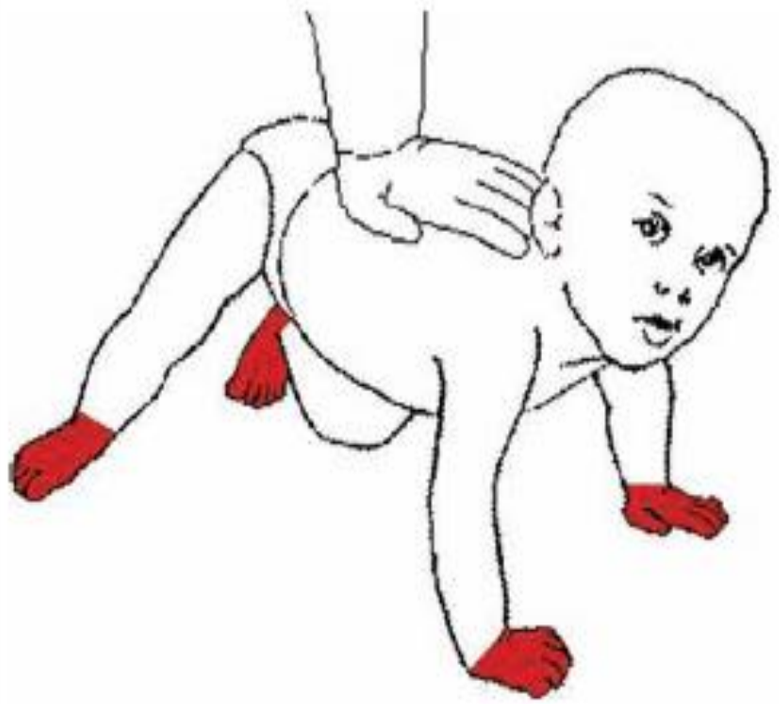

Figure 5 Abusive scald 'glove and stocking' pattern.

Figure 4 Abusive scald pattern.

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Best practice

EDITOR'S CHOICE

Which injuries may indicate child abuse?

S Maguire

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Frattura di femore sotto i 15 mesi

Frattura spiroide/obliqua di omero sotto i 3 anni

Fratture costali posteriori o anteriori

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Abusive head trauma: recognition and the essential investigation

Alison M Kemp

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Table 2 Clinical indicators of abusive head trauma

	AHT	Non-discriminatory	Non-AHT
Neuroradiology			
Extra-axial haemorrhage	SDH ► Multiple ► Interhemispheric ► Convexity ► Posterior fossa	► SAH ► Bilateral SDH	► EDH
Intracerebral features	► Hypoxic ischaemic injury ► Cerebral oedema	► Parenchymal injury	
History and clinical features			
History	► No history of trauma ► Low impact fall, with persistent neurological impairment ► Out-of-hospital CPR ► Initial history changes ► Other trauma explanations	► Low impact trauma, normal neurology ► Late presentation ► Sibling involvement	► High impact trauma
Clinical features	► Rib fractures ► Retinal haemorrhage ► Apnoea ► Seizures ► Head and neck bruising	► Skull fracture	
Retinal haemorrhage	► Bilateral ► Multilayered ► Extend to periphery ► Numerous	► Other retinal features	Rare but when occur ► Unilateral ► Posterior pole ► Scattered ► Few in number

AHT, abusive head trauma; CPR, cardiopulmonary resuscitation; EDH; extradural haematoma; SAH, subarachnoid haemorrhage; SDH, subdural haematoma.

La frattura cranica non è un indicatore

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Death, Childh Abuse, and Adverse Neurological Outcome Of Infants After an Apparent Life-Threatening Event

Bonkowsky et al , Pediatrics 2008

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471 well appearing ALTE infants

- F.O. a tutti
-Mantenere alto di livello di sospetto

Morti

Abuso 54(11%)
(17 entro un anno)

Epilessia 17 (3.6%)
Ritardo sviluppo 14 (3%)

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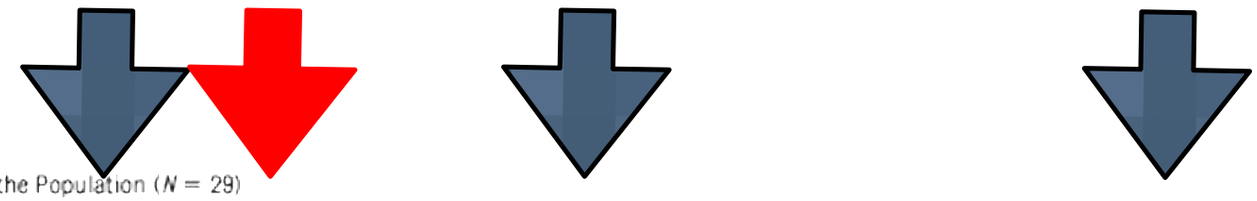

TABLE 2 Characteristics of the Population ($N = 29$)

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Abusive Head Trauma: Judicial Admissions Highlight Violent and Repetitive Shaking

Catherine Adamsbaum, Sophie Grabar, Nathalie Mejean and Caroline Rey-Salmon

Pediatrics 2010;126;546; originally published online August 9, 2010;
DOI: 10.1542/peds.2009-3647

M indicates male; F, female; CR, cardiopulmonary; ND, not determined.

[a] Died.

TABLE 2 Characteristics of the Population ($N = 29$)

Patient No.	Gender	Age, mo	Symptom at Diagnosis	Retinal Hemorrhage	Skin Lesions	Fracture	Other	Previous Injury
1	M	2	Vomiting	0	Ecchymoses	Ribs	Loss of weight	Loss of weight
2	M	1	Hip trauma	0	0	Clavicle, femur	0	0
3	M	6	Seizures	Bilateral	0	0	0	0
4[a]	M	6	Seizures	Bilateral	Ecchymoses	Skull	0	0
5[a]	M	84	Coma	ND	Ecchymoses, burns	Ribs, lumbar transverse	Loss of weight	Ecchymoses
6	M	1	Seizures	Bilateral	Ecchymoses	0	0	0
7[a]	M	6	Seizures	Bilateral	Ecchymoses	0	0	0
8[a]	F	2	CP arrest	Bilateral	Ecchymoses	0	Premature: 31 wk gestation	0
9	F	3	Anorexia	Bilateral	0	0	0	0
10	M	8	Seizures	Left	0	0	0	0
11	M	4	Seizures	Bilateral	0	0	0	0
12	M	6	Seizures	Bilateral	0	Ribs	0	Ecchymoses
13	F	5	Seizures	Bilateral	0	0	0	Ecchymoses
14[a]	M	42	Coma	ND	Ecchymoses	Elbow, skull	0	Fracture
15	M	5	Seizures	Bilateral	Ecchymoses	0	0	Ecchymoses
16	M	5	CP arrest	Bilateral	0	0	0	Ecchymoses
17[a]	M	2	Seizures	Bilateral	Ecchymoses	Ribs, metaphyses	0	0
18	M	5	Seizures	Bilateral	0	0	0	0
19	F	4	Hypotony	0	0	Metaphyses, skull	Premature: 34 wk gestation	Ecchymoses
20	M	6	Seizures	Bilateral	0	0	0	0
21	M	2	Seizures	Bilateral	0	Vertebra	0	0
22	M	10	Strabismus	Bilateral	0	0	0	0
23	F	6	Seizures	Bilateral	0	0	0	0
24[a]	M	1	Seizures	Bilateral	Ecchymoses	0	Tongue hematoma	0
25[a]	F	1	Seizures	0	0	0	0	0
26[a]	M	11	Seizures	Bilateral	0	0	0	0
27	M	11	Seizures	Bilateral	0	0	0	0
28	M	3	Seizures	0	0	Tibia (shaft and metaphysis)	0	0
29	F	4	Vomiting	Right	0	Rib	0	0

M indicates male; F, female; CR, cardiopulmonary; ND, not determined.

[a] Died.

TABLE 3 Imaging and Statements ($N = 29$)

Patient No.	Perpetrator	Delay of Symptoms	Impact	Shakings	Multifocal SDH Density	MRI, Day No.	Parenchyma	Autopsy/Histology
1	Father	—	—	Multiple	Hyperdense and hypodense	—	Normal	0
2	Father	—	—	Multiple	Hyperdense and hypodense	—	Porencephaly	0
3	Child minder	—	—	>15 over 2 mo	Hyperdense	—	Hypoxic ischemic	0
4[a]	Mother	—	—	>30 over 3 mo	Hyperdense	2	Hypoxic ischemic	SDH
5[a]	Mother and stepfather	—	yes	Single	Hyperdense	—	Hypoxic ischemic	SDH, hypoxic ischemic
6	Father	Immediate	—	Single	Hyperdense and hypodense	—	Hypoxic ischemic	0
7[a]	Mother	—	—	Single	Hyperdense	—	Hypoxic ischemic	SDH, contusions, hypoxic ischemic
8[a]	Father	—	—	At least 2 over 1 month	Hyperdense and hypodense	—	Hypoxic ischemic	SDH, cervical cord hematoma
9	Mother	—	—	At least 4 over 2 mo	Hyperdense and hypodense	—	Normal	0
10	Child minder	<1.5 h	—	Single	Hyperdense	5	Hypoxic ischemic	0
11	Father	Immediate	—	Single	Hyperdense		Hypoxic ischemic	0
12	Teenaged brother	—	yes	3 times	Hyperdense and hypodense	13	Hypoxic ischemic	0
13	Father	—	—	Multiple	Hyperdense and hypodense	—	Hypoxic ischemic	0
14[a]	Mother	Immediate	yes	Single	Hyperdense	—	Hypoxic ischemic	SDH, contusions
15	Father	—	—	>30 over 1 mo	Hypodense	—	Normal	0
16	Father	Immediate	—	Single	Hyperdense and hypodense	1	Hypoxic ischemic	0
17[a]	Father	—	yes	At least 10	Hyperdense and hypodense	3	Hypoxic ischemic	SDH, hypoxic ischemic
18	Father	—	—	At least 2 over 1 mo	Hyperdense and hypodense	—	Normal	0
19	Mother	—	—	>15 over 2 mo	Hypodense	2	Hypoxic ischemic	0
20	Child minder	—	—	At least 3	Hyperdense and hypodense	1	Hypoxic ischemic	0
21	Mother	<3 h	—	Single	Hyperdense and hypodense	0	Hypoxic ischemic	0
22	Stepfather	—	—	>10	Hyperdense and hypodense	2	Normal	0
23	Child minder	<1.5 h	—	Single	Hyperdense and hypodense	2	Hypoxic ischemic	0
24[a]	Father	—	—	Single	Hyperdense	—	Hypoxic ischemic	SDH, contusions, edema
25[a]	Mother	<1 h	—	Single	Hyperdense and hypodense	—	Hypoxic ischemic	0
26[a]	Child minder	<1 h	yes	Single	Hyperdense	5	Hypoxic ischemic	SDH
27	Child minder	<3 h	—	Single	Hyperdense	0	Hypoxic ischemic	0
28	Father	—	—	3 over 1 mo	Hyperdense	2	Hypoxic ischemic	0
29	Mother	—	—	3 over 3 wk	Hyperdense and hypodense	1	Normal	0

— indicates that data were not available.

[a] Died.

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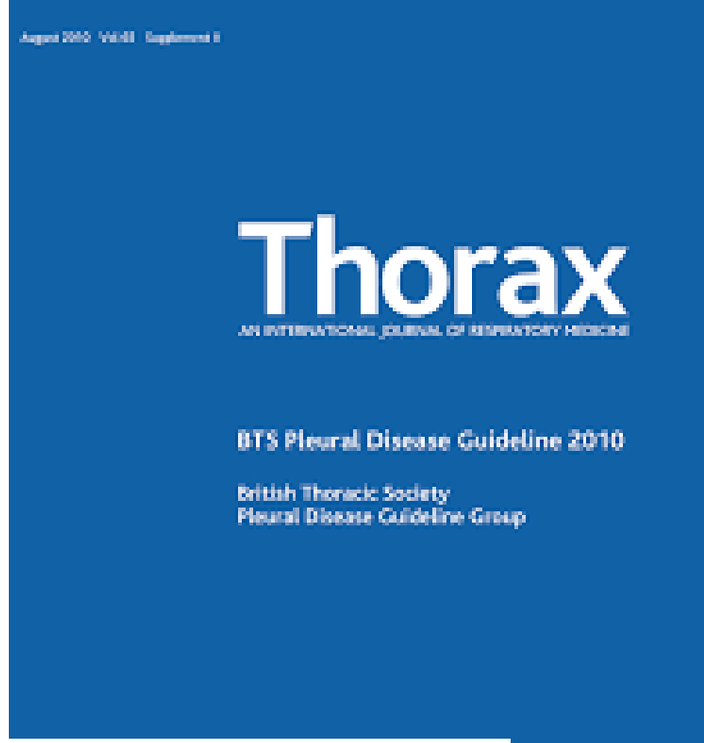
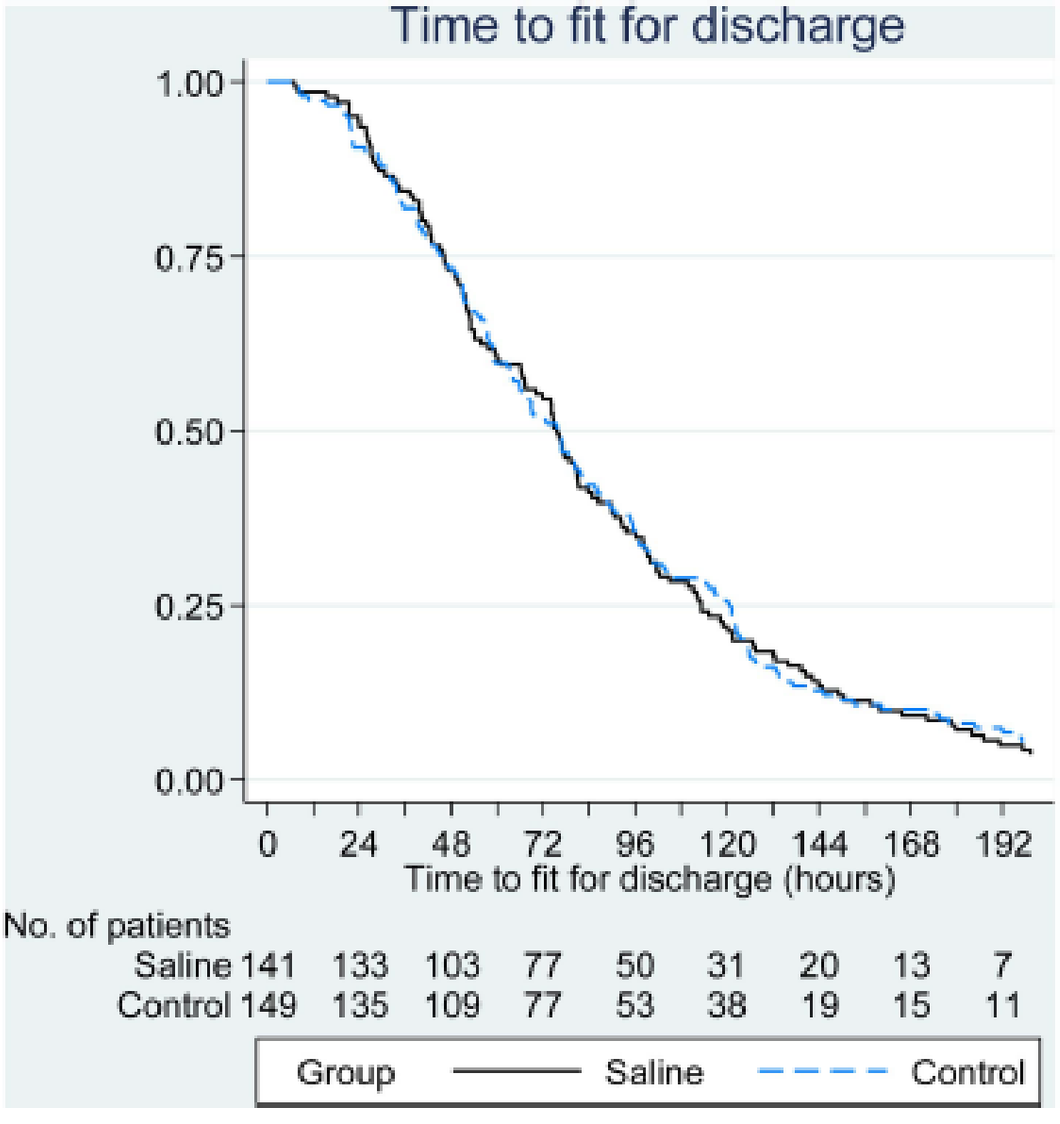
ente male Junior

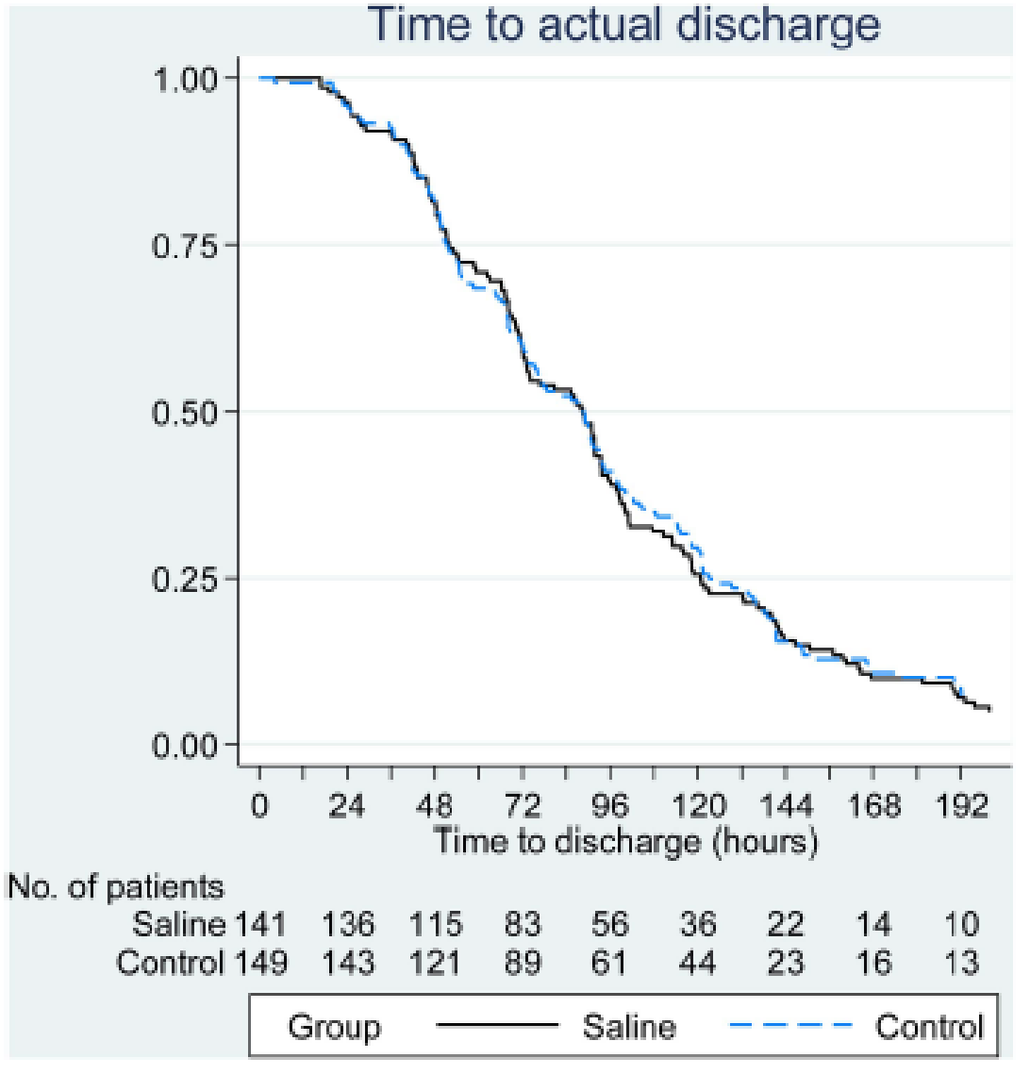
ORIGINAL ARTICLE

SABRE: a multicentre randomised control trial of nebulised hypertonic saline in infants hospitalised with acute bronchiolitis

Mark L Everard,[1] Daniel Hind,[2] Kelechi Ugonna,[3] Jennifer Freeman,[4] Mike Bradburn,[2] Cindy L Cooper,[2] Elizabeth Cross,[2] Chin Maguire,[2] Hannah Cantrill,[2] John Alexander,[5] Paul S McNamara,,[6] on behalf of The SABRE Study Team







ure 3 Cumulative survival plot for actual time to discharge.

L'ipertonica è ben tollerata?

Pediatric Pulmonology

A Randomized Trial of Nebulized 3% Hypertonic Saline With Salbutamol in the Treatment of Acute Bronchiolitis in Hospitalized Infants

Pedro Flores, MD, PhD,* Ana Luisa Mendes, MD, and Ana S. Neto, MD, PhD

TABLE 5— Adverse Effects Noted in Each Group N(%)

Symptom	Hypertonic saline Group I (HS) N = 33	Normal saline Group II (NS) N = 35	*P* value
Sudden bronchial constriction	2 (6.1)	2 (5.7)	0.952
Apnoe	0	0	
Cyanosis	0	0	
Exacerbation of coughing	15 (45.5)	7 (20.0)	0.025
Excessive rhinorrhoe	19 (57.6)	11 (31.4)	0.030
Saturation dips	0	0	
Tachycardia >200 cpm	0	0	
Agitation	9 (27.3)	12 (34.3)	0.532
Vomiting	0	0	

Pediatric Pulmonology

ACTA PÆDIATRICA
NURTURING THE CHILD

Acta Pædiatrica ISSN 0803-5253

REGULAR ARTICLE

Nasal irrigation with saline solution significantly improves oxygen saturation in infants with bronchiolitis

Silvana Schreiber[1], Luca Ronfani[1], Sergio Ghirardo[2], Federico Minen (federicominen@gmail.com)[3], Andrea Taddio[1,2], Mohamad Jaber[2], Elisa Rizzello[2], Egidio Barbi[1]

1.Institute for Maternal and Child Health, IRCCS Burlo Garofolo, Trieste, Italy
2.University of Trieste, Trieste, Italy
3.Struttura Operativa Complessa di Pediatria, Azienda Ospedaliera Santa Maria degli Angeli, Pordenone, Italy

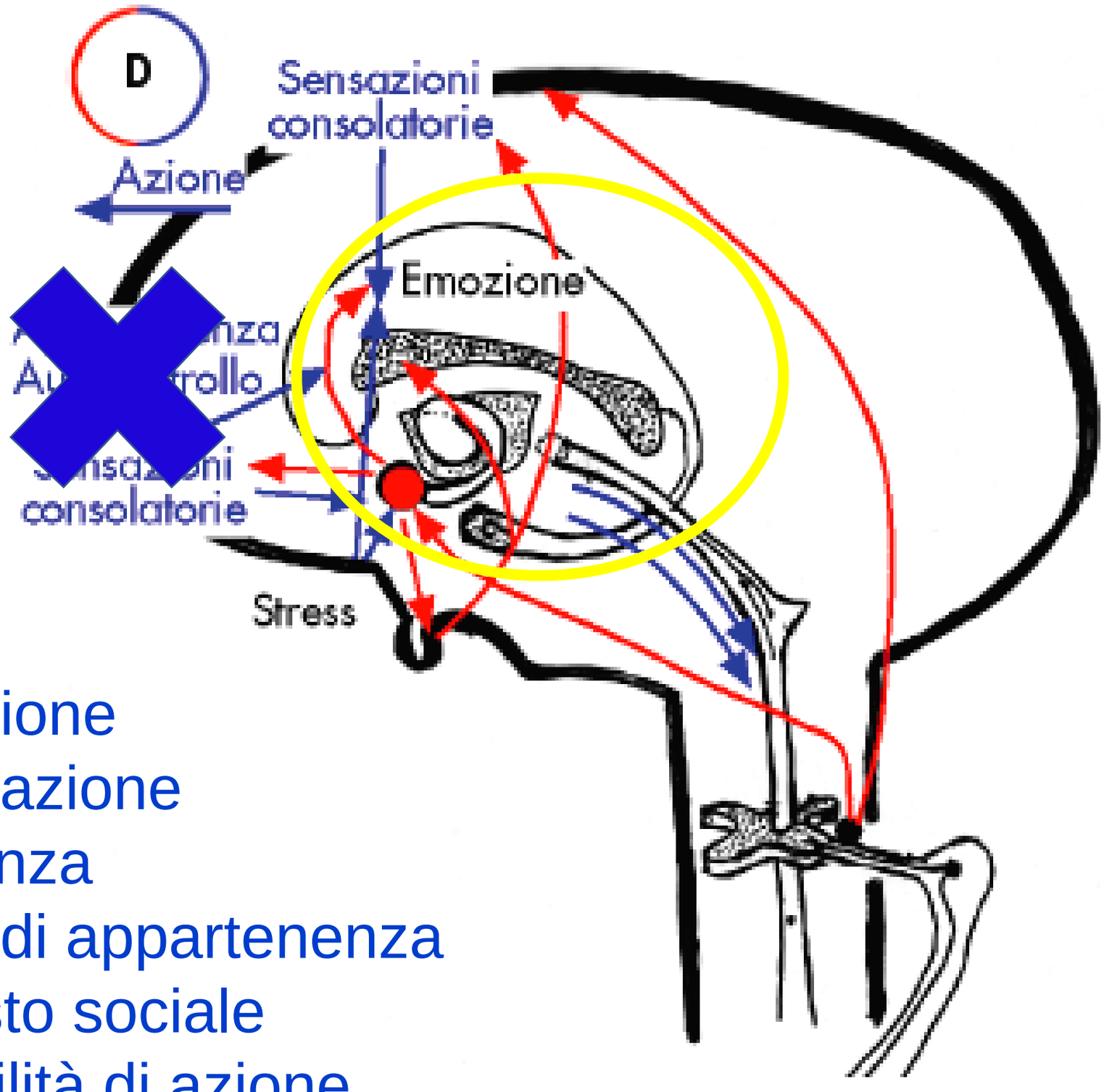
Table 1 Comparisons of oxygen saturation values among the three study groups at each follow-up time.

	Isotonic group (n = 47)	Hypertonic group (n = 44)	Standard care group (n = 42)	p Value*

Table 2 Subjects with oxygen saturation > 94% at each follow-up time by study group. Results are p

	Isotonic group (n = 47)	Hypertonic group (n = 44)	Standard care group (n = 42)	p Value
5 minutes	25 (53.2%)	15 (34.1%)	11 (26.2%)	0.03
15 minutes	37 (78.7%)	17 (38.6%)	19 (45.2%)	<0.001
20 minutes	35 (74.5%)	27 (61.4%)	18 (42.9%)	0.01
50 minutes	39 (83.0%)	35 (79.5%)	19 (45.2%)	<0.001

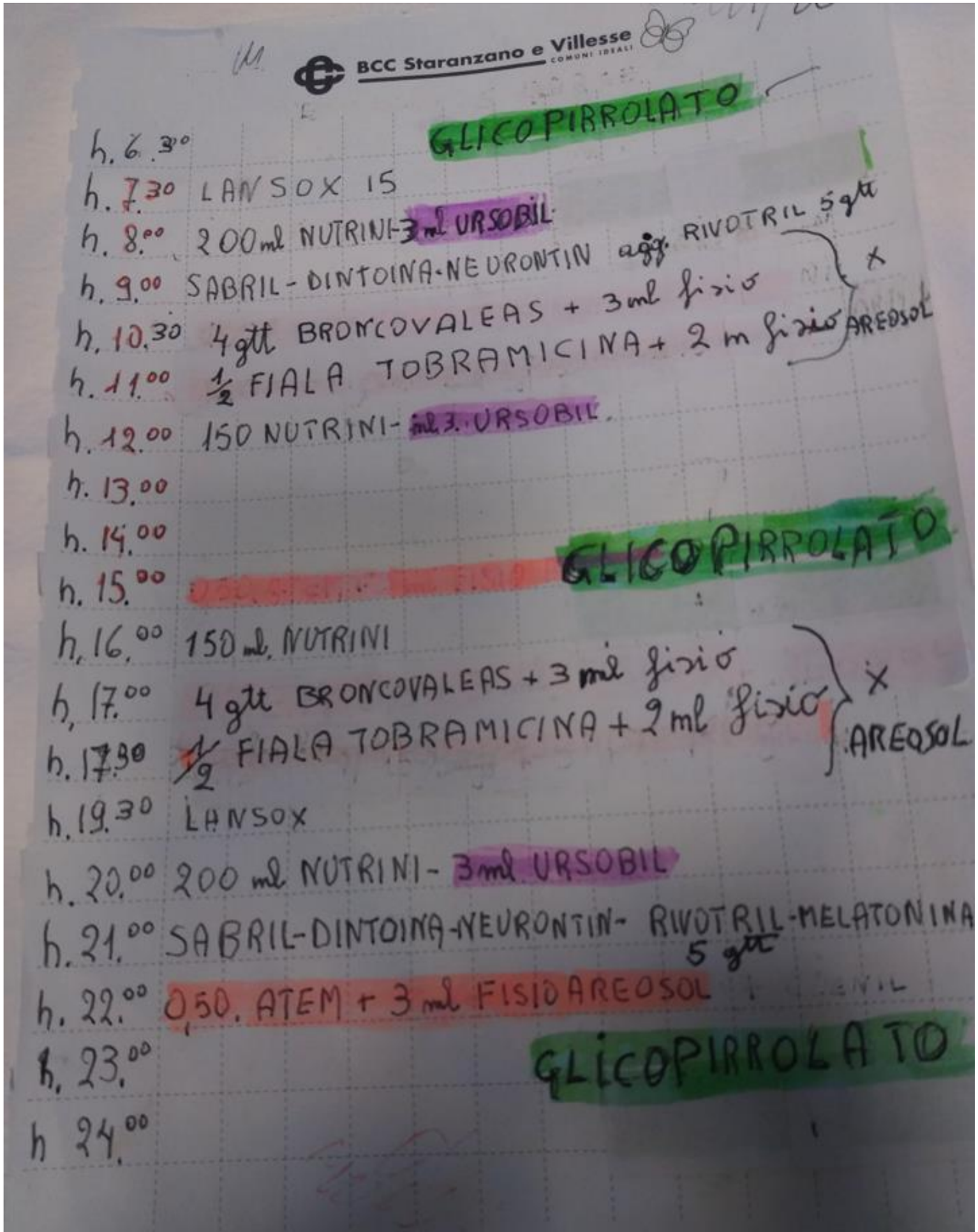

Io mi arrendo.....
Buonanotte
SCHULZ



Emozioni
Paura
Ansia
Stress

Distrazione
Consolazione
Resilienza
Senso di appartenenza
Contesto sociale
Possibilità di azione

SOME SPECIFIC ISSUES ON PAIN IN PAEDIATRICS:
SUMMARY AND REVIEW OF THE PRESENT KNOWLEDGE AND PRACTICE
(Medico e Bambino 2010;29:289-297) FRANCO PANIZON[1], EGIDIO BARBI[2]



La vita vera...

..più aspirazione della saliva ogni 2-3 ore “se no soffoca” ....

The Health and Well-Being of Caregivers of Children With Cerebral Palsy

Parminder Raina, PhD*‡; Maureen O'Donnell, MD§; Peter Rosenbaum, MD‖¶#; Jamie Brehaut, PhD**;
Stephen D. Walter, PhD*; Dianne Russell, MSc*¶#; Marilyn Swinton, BSc¶; Bin Zhu, MSc*‡; and
Ellen Wood, MD††

PEDIATRICS Vol. 115 No. 6 June 2005

Providing parents with cognitive and behavioral strategies to manage their child's behavior may have the potential to change caregivers' health outcome.

Pain Research and Management
Volume 2017, Article ID 2514920, 11 pages
https://doi.org/10.1155/2017/2514920

Research Article

Developing a Sense of Knowing and Acquiring the Skills to Manage Pain in Children with Profound Cognitive Impairments: Mothers' Perspectives

Bernie Carter,[1] Janine Arnott,[2] Joan Simons,[3] and Lucy Bray[1]

La parola chiave è incertezza....

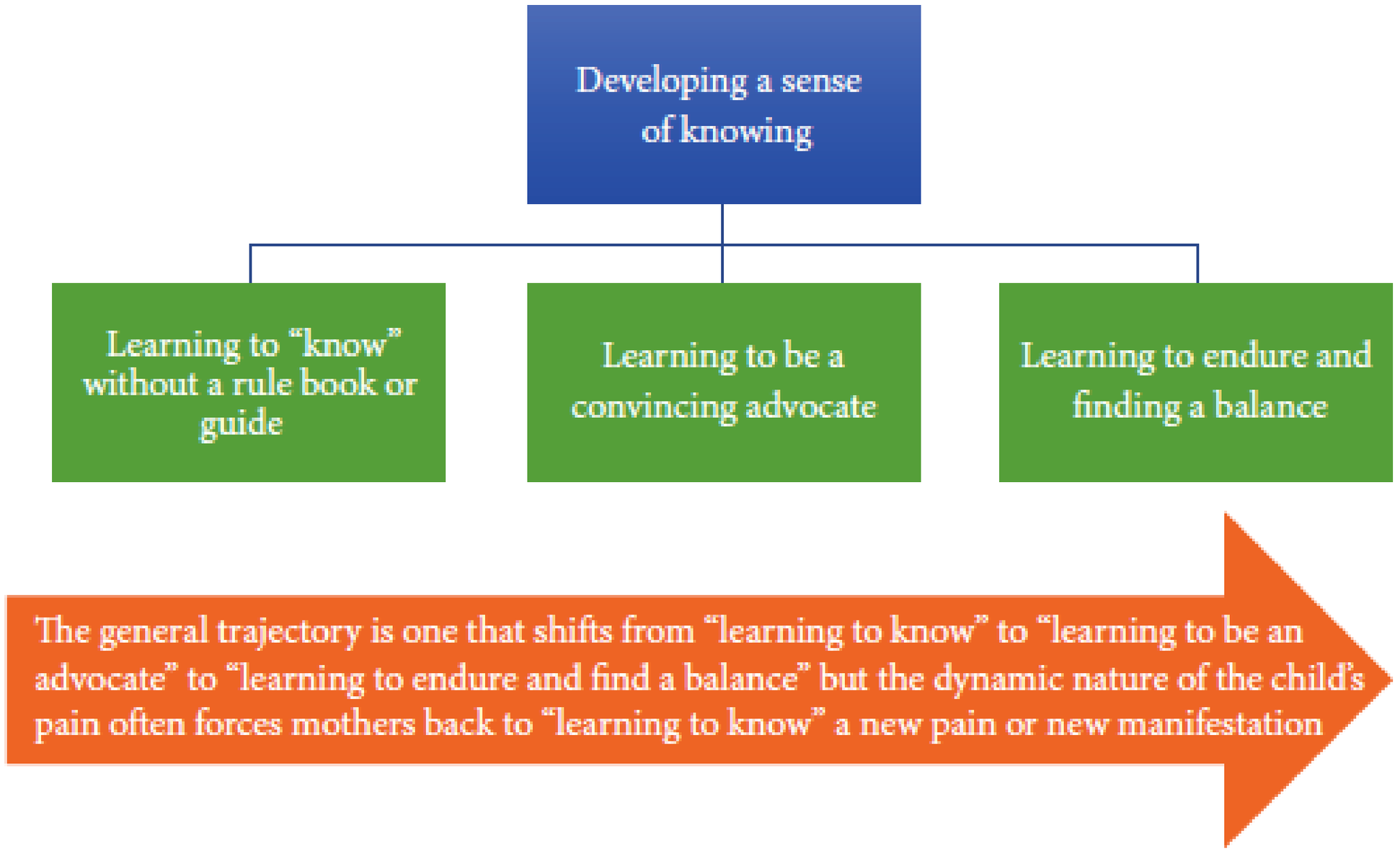


FIGURE 1: Metatheme and core themes.

PLOS ONE

RESEARCH ARTICLE

Early Mortality and Primary Causes of Death in Mothers of Children with Intellectual Disability or Autism Spectrum Disorder: A Retrospective Cohort Study

Published: December 23, 2014

Jenny Fairthorne[1]*, Geoff Hammond[2], Jenny Bourke[1], Peter Jacoby[1], Helen Leonard[1]

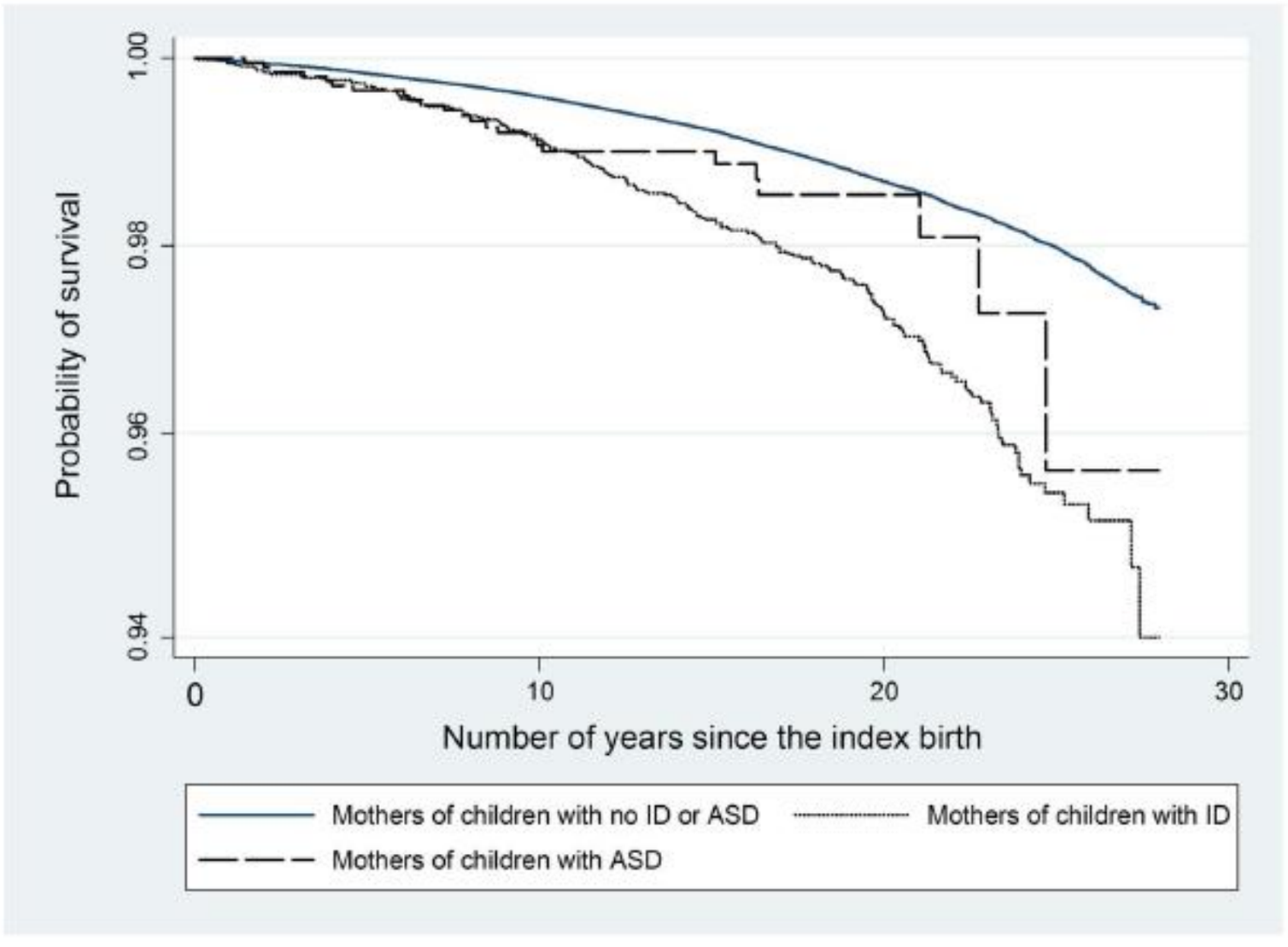


Fig. 2. Kaplan-Meier survival rates of mothers of children with no intellectual disability or ASD, mothers of children with intellectual disability and mothers of children with ASD.

- all women (300123) who gave birth to a child in Western Australia 1983-2005
- mothers of children with intellectual disability:
- 40% more likely to die of cancer
- 150% more likely to die of cardiovascular disease
- 200% more likely to die from misadventure

- increased stress
- time restraints, reduced levels of self care
- more challenges in everyday life
- more depression
- less sleep
- more risk factors for accidents
- more risk factors for suicide

Il potere della parola, almeno con i genitori...

- bisogna dare parole al dolore perchè la pena che non si esprime sussurra al cuore sovraccarico e gli ordina di spezzarsi

- ricevete il conforto che potete perchè lunga è la notte che non trova mai il suo giorno. W. Shakespeare. Macbeth.

CLINICAL PRACTICE GUIDELINE Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Brief Resolved Unexplained Events (Formerly Apparent Life-Threatening Events) and Evaluation of Lower-Risk Infants

- Descritto come **breve** (durata <1 minuto ma tipicamente <20-30 secondi) e **risolto** (il bambino è tornato alla sua condizione precedente dopo l'evento)
- **Anamnesi ed esame obiettivo all'ingresso senza elementi di rilievo**
- Presenza di più di uno dei seguenti :
- **Cianosi o pallore**
- **Respirazione assente, ridotta o irregolare**
- **Marcata modifica del tono (ipertonia o ipotonia)**
- **Alterato livello di responsività**
- è una diagnosi medica e può essere fatta solo dopo che a seguito di un'anamnesi ed una visita non ci sia spiegazione per l'evento.

TABLE 1 BRUE Definition and Factors for Inclusion and Exclusion

	Includes	Excludes
Brief	Duration <1 min; typically 20–30 s	Duration ≥1 min
Resolved	Patient returned to his or her baseline state of health after the event	At the time of medical evaluation:
	Normal vital signs	Fever or recent fever
	Normal appearance	Tachypnea, bradypnea, apnea
		Tachycardia or bradycardia
		Hypotension, hypertension, or hemodynamic instability
		Mental status changes, somnolence, lethargy
		Hypotonia or hypertonia
		Vomiting
		Bruising, petechiae, or other signs of injury/trauma
		Abnormal weight, growth, or head circumference
		Noisy breathing (stridor, sturgor, wheezing)
		Repeat event(s)

TABLE 1 BRUE Definition and Factors for Inclusion and Exclusion

	Includes	Excludes
Unexplained	Not explained by an identifiable medical condition	Repeat event(s) Event consistent with GER, swallow dysfunction, nasal congestion, etc History or physical examination concerning for child abuse, congenital airway abnormality, etc
Event Characterization		
Cyanosis or pallor	Central cyanosis: blue or purple coloration of face, gums, trunk Central pallor: pale coloration of face or trunk	Acrocyanosis or perioral cyanosis Rubor

TABLE 1 BRUE Definition and Factors for Inclusion and Exclusion

	Includes	Excludes
Absent, decreased, or irregular breathing	Central apnea Obstructive apnea Mixed obstructive apnea	Periodic breathing of the newborn Breath-holding spell
Marked change in tone (hyper- or hypotonia)	Hypertonia	Hypertonia associated with crying, choking, or gagging due to GER or feeding problems
	Hypotonia	Tone changes associated with breath-holding spell Tonic eye deviation or nystagmus Tonic-clonic seizure activity Infantile spasms
Altered responsiveness	Loss of consciousness Mental status change Lethargy Somnolence Postictal phase	Loss of consciousness associated with breath-holding spell

Alto rischio

- Lattanti di età <2 mesi
- Nati pretermine (rischio aumentato nei lattanti nati <32 settimane, che si riduce una volta raggiunta l'età di 45 settimane postconcezionali).
- Storia di più di un evento
- Necessità di RCP (stabilita dal medico)

Basso rischio

Età gestazionale ≥32 settimane ed età postconcezionale ≥45 settimane

Primo episodio classificabile come BRUE (assenza di precedenti o cluster di eventi)

Durata dell’evento <1 minuto

Nessuna necessità di RCP (determinata da medico)

Assenza di fattori di rischio in anamnesi

BRUE A BASSO RISCHIO

Clinicians should not

- Obtain full blood count, electrolytes, blood or CSF culture, metabolic tests including ammonia or amino acids or blood gasses.
- Perform a chest X-ray, echocardiogram, EEG or studies for reflux.
- Initiate home cardiorespiratory monitoring.
- Prescribe acid suppression therapy or antiepileptic medication.

BRUE A BASSO RISCHIO

Clinicians need not

- Admit the patient to hospital solely for cardiorespiratory monitoring.
- Obtain viral respiratory test, urinalysis, blood glucose, serum bicarbonate, lactic acid.
- Obtain neuroimaging.


Non capisco...ci insegnano
che la verita è giusta, e quando
la dici, tutti si offendono.

Published in final edited form as:
Pediatr Infect Dis J. 2014 April ; 33(4): 387–392. doi:10.1097/INF.0000000000000119.

Comparative Effectiveness of Ceftriaxone in Combination with a Macrolide Compared with Ceftriaxone Alone for Pediatric Patients Hospitalized with Community Acquired Pneumonia

Outcome	Ceftriaxone alone (n=8892)	Ceftriaxone + macrolide (n=4701)	p-value
Ages 5–17 years			
Length of stay, days (mean, SD) Median (IQR)	2.60 (1.72) 2 (2–3)	2.48 (1.56) 2 (1–3)	0.02
Total hospital costs, USD (mean, SD) Median (IQR)	$4173 (3874) 3258 (2191–4896)	$4306 (5330) 3366 (2328–4979)	0.03
Transfer to intensive care unit >= day 2 (n, %)	26 (1.3%)	13 (0.7%)	0.71
Inpatient mortality (n, %)	0 (0%)	1 (0.04%)	0.30
All cause < 30 d readmission (n, %)	28 (1.1%)	16 (.7%)	0.10
Pneumonia-related <30 d readmission (n, %)	12 (0.5%)	11 (0.6%)	0.96

Durata più corta del 5%

Devo trattare 7 bambini perchè 1 stia 1 giorno in meno in ospedale

REVIEW ARTICLE

Treatment of Mycoplasma Pneumonia: A Systematic Review

AUTHORS: Eric Biondi, MD,[a] Russell McCulloh, MD,[b] Brian Alverson, MD,[c] Andrew Klein, BS,[a] Angela Dixon, BSN, MLS, AHIP,[a] and Shawn Ralston, MD[d]

[a]*Department of Pediatrics, University of Rochester, Rochester, New York;* [b]*Department of Pediatrics, Children's Mercy Hospitals & Clinics, Kansas City, Missouri;* [c]*Department of Pediatrics, Hasbro Children's Hospital, Providence, Rhode Island; and*

abstract

BACKGROUND AND OBJECTIVE: Children with community-acquired lower respiratory tract infection (CA-LRTI) commonly receive antibiotics for *Mycoplasma pneumoniae*. The objective was to evaluate the effect of treating *M. pneumoniae* in children with CA-LRTI.

L'incidenza di polmoniti da mycoplasma è riportata tra il 10 e 40% **(20%)**

Review di tutti i lavori in cui è usato un farmaco anti-mycoplasma versus farmaco non attivo

PEDIATRICS Volume 133, Number 6, June 2014

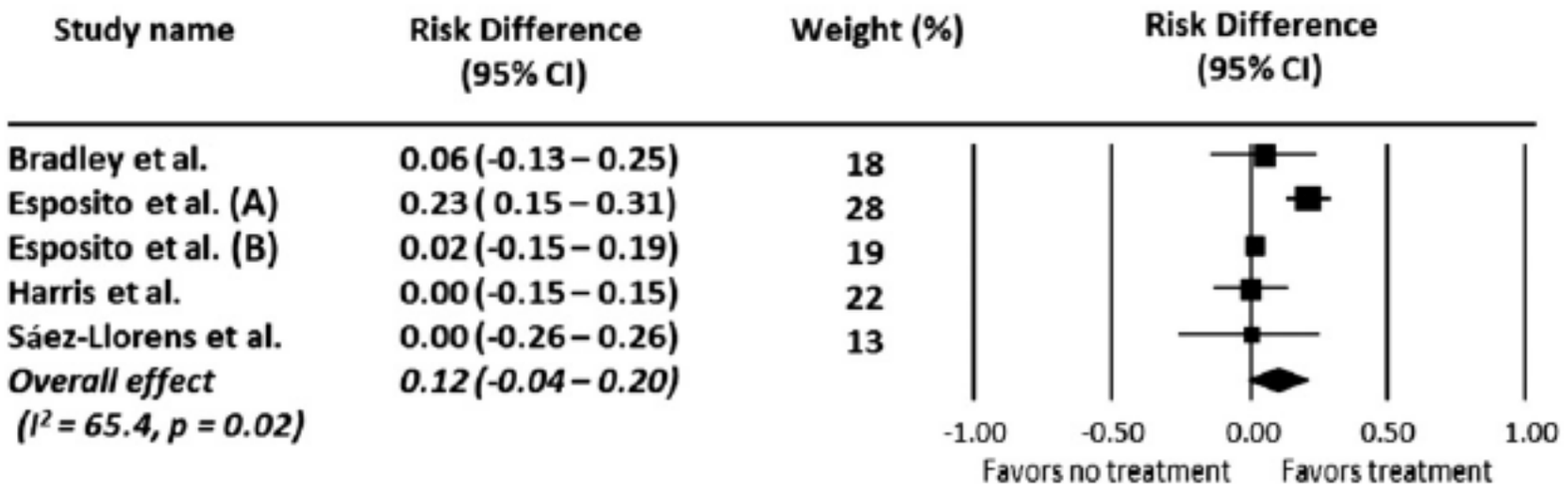


FIGURE 2

Meta-analysis of randomized trials comparing spectrum and nonspectrum treatment of *M. pneumoniae* in children. Studies were weighted by size and degree of heterogeneity. The overall effect (diamond) represents the pooled risk differences of the 5 studies. The confidence interval crosses 0.00, suggesting a lack of statistical significance.

−4% to 20%). This finding suggests that 12% of children treated with a macrolide will have more rapid clinical improvement, corresponding to a number needed to treat of 8.33, but

..12% dei bambini trattati con macrolide avrà miglioramento più rapido ...

NNT pari a 8.33 ...

“the available literature does not currently support treatment of CA-LRTI secondary to Mycoplasma P “