e-Poster Presentation

Clinical Pediatrics 2023





4th World Congress on

Pediatrics and Clinical Pediatrics

July 01, 2023 | Webinar

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Received Date: 23-10-2022 | Accepted Date: 28-10-2022 | Published Date: 30-07-2023

Single-stage biosynthetic cellulose dressing (Epiprotect) versus nonadherent gauze dressing in pediatric burns

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Introduction: Paediatric burn is a common emergency presentation with a variety of treatment options available. Major parental concerns include pain, healing and scarring, in addition to high parental anxiety. Epiprotect is a biosynthetic cellulose-based sheet, applied as a single-stage first-layer contact dressing following initial debridement.

Materials and Methods: A retrospective case-control comparison study was carried out in our hospital on 28 patients, 14 with biosynthetic cellulose, and 14 with non-adherent gauze. Pain and parental anxiety were measured by the parental perception of the child's pain on the Wong-Baker Faces pain rating scale and STAI-6 questionnaire (compatible with the STAI-S scoring system) respectively in the first clinic visit during outer dressing change. Scar score was calculated using the Vancouver scar scale (VSS).

Results: Patients in both groups had a similar demographic and clinical distribution of location, mechanism of burn, first aid, surface area and depth of the burn. Pain and parental anxiety were significantly reduced in the cellulose dressing group ($p = 0.0001$). The time to complete healing was similar in both groups. The mean VSS scar score was 4 (1–5) in the cellulose dressing group compared to 6 (4–11) in the non-adherent gauze group ($p = 0.0463$). Two patients developed hypertrophied scars in the non-adherent gauze group. The mean number of outpatient clinic visits in the cellulose dressing group was 2.5 (1–5) as compared to 3 (2–6) in the non-adherent gauze group ($p = 0.0607$).

Conclusion: Single-stage first-layer application of biosynthetic cellulose dressing is associated with reduced pain, parental anxiety, and improved scarring. The dressing is safe and can be applied to patients with superficial and mixed-depth burns.

Recent Publication

1. A. Bener, K.M. Al-Salman, et al. Injury mortality and morbidity among children in the United Arab Emirates.Eur J Epidemiol, 14 (2) (1998), pp. 175-178, 10.1023/a:1007444109260
2. Michal Grivna, Hani O. Eid, et al. Burns, 40 (3) (2014), pp. 500-505, 0.1016/j.burns.2013.08.010
3. Regan Medical UK- Part of Joint operations family, https://www.regenmedical.co.uk/epiprotect/.

Biography

Priyanka Lalwani is a dedicated and compassionate pediatric emergency specialist at the Al Jalila Children's Specialty Hospital in Dubai, United Arab Emirates. With years of experience and a passion for providing exceptional care to children, she plays a crucial role in diagnosing and treating pediatric emergencies. Priyanka's expertise and commitment to her field make her an invaluable asset to the hospital, ensuring that young patients receive the highest standard of medical attention. Her unwavering dedication to improving children's health and well-being has earned her recognition and respect among her peers and patients alike.

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Accepted Abstracts

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Pediatrics and Clinical Pediatrics

July 01, 2023 | Webinar

Recived Date: 30-01-2023 | Accepted Date: 05-02-2023 | Published Date: 30-07-2023

Yeah for TXA! implementation of heavy menstrual bleeding protocol in pediatric emergency

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Adolescents may suffer from heavy menstrual bleeding (HMB) in the first two years from menarche to established ovulatory cycles. Menorrhagia can impact school, social, and occupational performance. Safe treatment options are available for HMB in the adolescent population. Patients may experience delays due to pending investigations, consultation waitlists, and inexperience with treatment in the adolescent population. In this quality improvement project, we completed a 12-month review of cases of HMB presenting to BC Children's Hospital Emergency Department. From this result, 15% had mild anemia, 15% had moderate anemia, with 85% presenting hemodynamically stable. There were no diagnoses of bleeding disorders in those presenting for emergent assessment. A multidisciplinary team comprised of emergency medicine, pediatric and adolescent gynecology, hematology, pharmacy, and pediatrics met to determine best practice for initial work-up, treatment and consultation. A HMB protocol was developed that could be initiated in the emergency room for mild, moderate, and severe anemia. This protocol has well received and is now available province-wide. We have reduced unnecessary investigations, time to first medication, and streamlined consultation process.

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4th World Congress on

Pediatrics and Clinical Pediatrics

July 01, 2023 | Webinar

Received date: 14-12-2022 | Accepted Date: 20-12-2022 | Published Date: 30-07-2023

Does cesarean section pose a risk of respiratory syncytial virus bronchiolitis in infants and children?

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Objective: To determine the risk of acquiring acute respiratory syncytial virus (RSV) bronchiolitis in infants and children delivered by the mode of cesarean section (C-section).

Methods: A retrospective and descriptive study was conducted at Hamad Medical Corporation. Patients with ages 0 to 36 months hospitalized with acute bronchiolitis were included in the study.

Results: The risk of RSV bronchiolitis was observed to be higher among C-section delivery compared to normal spontaneous vaginal delivery [odds ratio=1.10; 95% confidence interval (0.57, 1.80); P=0.965]; however, it was not statistically significant. Gestational age ≤35 weeks was significantly associated with increased risk of RSV bronchiolitis compared to gestational age >35 weeks [odds ratio=3.12; 95% confidence interval (1.53, 6.38); P=0.002].

Conclusions: Delivery by C-section does not appear to increase the risk of RSV bronchiolitis in infants compared with normal spontaneous vaginal delivery.

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Pediatrics and Clinical Pediatrics

July 01, 2023 | Webinar

Received Date: 09-02-2023 | Accepted Date: 13-02-2023 | Published Date:30-07-2023

Prefeeding interventions improve oral feeding in preterm infants

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Objective: To assess whether oral stimulation (OS), nonnutritive sucking (NNS) and combined tactile/kinesthetic (T/K) interventions can improve the effects of oral feeding in preterm infants. Methods: A retrospective review was performed from 2014 to 2016, in which one hundred thirty preterm infants were separated into two intervention groups (the OS + NNS group and the OS + NNS + T/K group) and one control group. Infants in the two intervention groups received 30 min of interventions a day. All interventions started 48 h after stopping nasal continuous positive airway pressure until participants reached complete oral feeding.

Results: The transition times of the OS + NNS, OS + NNS + T/K, and control groups from the introduction of oral feeding to independent oral feeding were 9.03 ± 0.58, 7.20 ± 0.28, and 12.17 ± 0.64 days, respectively (P <0.05). The infants' weights at full oral feeding in the OS + NNS, OS + NNS + T/K, and control groups were 1834.58 ± 47.96, 1999.17 ± 92.62, and 1725.87 ± 40.34 g, respectively (P = 0.007). Further post hoc analyses indicated that the weight gain at full oral feeding in the OS + NNS and OS + NNS + T/K groups were more significant than the control group (P = 0.012 and P = 0.036, respectively).

Conclusion: OS + NNS and OS + NNS + T/K interventions could shorten the transition time from tube feeding to independent oral feeding; OS + NNS and OS + NNS + T/K interventions improved weight gain compared to the control group. Furthermore, the OS +NNS + T/K group was superior to the OS + NNS group regarding transition time and weight gain.

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