What to NOT do in Pediatrics – a periodically updated RED list

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Abstract

This paper proposes an *important RED list of what to NOT do in pediatrics*, with the conviction that *this red list should be taught from the first year of medicine and repeated in every single year of medical teaching, in all medical universities from all countries worldwide*: the work-hypothesis (and the main motivation of this paper) is that *insisting on this red list in all medical teaching systems may significantly decrease the rate of medical/pediatric malpractice thus may significantly improve the health status of any child population from any country*.

This paper will be periodically updated so that to increase the efficiency of this proposed medical teaching method based on the principle *that any medical specialty should be taught starting (and repetitively insisting!) on what to NOT do in that medical specialty practice!*

This paper continues the line of other medical articles/preprints of the same author [**1**, **2**, **3**, **4**, **5**, **6**].

This list is mainly addressed to young medical students, but also to young medical doctors, nurses etc. from the beginning of their careers.

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I. A RED list of what to NOT do in Pediatrics (including other important pediatric advices)

IMPORTANT ABBREVIATIONS (used in this paper): *rule/advice* given *from medical manual* (**FMM**) and/or *from personal experience* (**FPE**).

1. **NEVER** consult a neonate, breastfeeding infant or infant without checking his anterior fontanelle (**AF**) and posterior fontanelle (**PF**) (NO MATTER the reasons he presented for medical consult)! (**FMM&FPE**)
   a. **BECAUSE** a bulging AF may very probably indicate meningitis, which is a medical emergency and should be screened for meningeal signs immediately!
   b. **BECAUSE** a delay in PF closure is associated with congenital hypothyroidism (**CH**) which is an important medical diagnosis, which CH should be screened and excluded as early as possible!
   c. **ADDITIONAL ADVICE.** When you consult an infant with open AF and already have the stethoscope on your ears DO NOT hesitate to put your stethoscope on that open AF: any possible murmur you may hear should be firstly re-checked with a cranial ultrasound (including Doppler ultrasound) to start the screening of a possible intracranial vascular malformation.
2. **NEVER** let go a child from your consulting room without verifying his/her meningeal signs, NO MATTER the reasons of presentation to that consult! (**FMM&FPE**)
3. **NEVER** let go a breastfeeding baby or infant with raised/bulging anterior fontanelle (**NO MATTER** if he/she has fever or not) without a computer tomography (**CT**) scan or a dilated (eye-)fundus examination (if the CT scan isn't available) and, if these two exams are normal, proceed with a lumbar puncture! (**FMM&FPE**)
4. **ALTERNATIVELY USE** dilated (eye-)fundus examination when you cannot temporarily use (by any objective reason) CT scans for periodical screening of intracranial hypertension syndrome (**ICHS**) in a child or adult with any anterior chronic disease producing ICHS and indication for ICHS screening. (**FPE**)
5. **NEVER** let go a lethargic neonate who refuses maternal milk (NO MATTER if he/she has fever or not!) without carefully lab and/or imaging screening for potential infection/sepsis. (**FMM&FPE**)
6. **ALWAYS** ask a breastfeeding mother if her breastfeeding baby (**BFB**) frequently falls asleep too rapidly (under 5-10 minutes) after starting BF: this BF-associated fatigue may indicate a **heart condition (imposing ECG and heart ultrasound)**, **NO MATTER IF** that BFB has normal weight and height or not AND NO MATTER IF that BFB has any heart murmurs or not. (**FPE**)
7. **ALWAYS** ask parents if their **underweight child** (**UC**) has a particularly **salted sweating** when kissed on his/her sweated head and/or skin: ALSO ask those parents if their UC has stools which look as if "**coated in oil**" (which may indicate steatorrhea). **NO MATTER IF** the answers of both anterior questions are negative, ALWAYS additionally ask the mother (**1**) if her child passed stool from his/her first day of life AND (**2**) if her child has chronic constipation AND (**3**) if her child chronically snores in his/her sleep without any signs of acute infection AND (**4**) if the rectal mucosa of her child becomes visible when he/she passes stools (NO MATTER IF constipated or not). All these details are valuable anamnestic "clues" for a possible undiagnosed cistic fibrosis and the child should be screened for CF firstly by iontophoresis and then by genetic tests of CFTR gene in selected cases. (**FMM&FPE**)
8. **NEVER** let go a child consulted for the first time without examining his/her genitals given the relatively high prevalence of intersex (which, at least in some populations, may reach the prevalence of red hair in the world's human population, which is about 1-2%!). (**FMM&FPE**)
9. **ALWAYS** check the abdomen and consider a possible acute appendicitis and/or peritonitis (**EVEN IF** the peritoneal signs are not present!) in a child who recently received **any antibiotic prior to the consultation** (which antibiotic may partially/totally temporarily "hide" the clinical signs of peritonitis which is a medical emergency with possible fatal

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outcome if not surgically treated as soon as possible)! (**FMM&FPE**)

10. **ALWAYS** screen the stools for Clostridium difficile (by detecting toxins and stool cultures) in a child with diarrhea (with or without mucus and/or blood) AND recent history of oral or parenteral antibiotic treatment. (**FMM&FPE**)

11. The combination between **rhinorrhea** (with or without nasal obstruction) and **pharyngitis** (with or without tonsillitis, with or without cough) **WITH (micro-)vesicles** is highly predictive for a viral (NOT bacterial or fungal!) infection: that is why YOU SHOULDN'T PRESCRIBE ANY ANTIBIOTIC unless a very strong additional evidence for bacterial infection (positive cultures, CRP>10-15mg/L, leukocytosis with neutrophilia etc.)!

12. IF/WHEN you prescribe antibiotics to a child (no matter if orally or parenterally), **ALWAYS** teach parents how to prevent secondary genital and/or oral candidiasis (frequently caused by antibiotics) by using sodium bicarbonate (**SB**) solution (prepared with one full teaspoon of SB for each 100 ml of boiled-then-cooled water) on all antibiotherapy interval (genital applications [by topical pulverization or applications with a small cotton swab] after each micturition and stool AND oral gargles where it's possible) plus 2-3 additional days (util the antibiotics is fully eliminated from the body by urine and/or stools). You may give all patients (including to adult patients) small printed flyers (informing them on this candidiasis-preventive treatment adjuvant to antibiotherapy). (**FPE**)

13. **ALWAYS** prescribe adjuvant (bacterial +/- fungal) probiotics when you prescribe antibiotics (**NO MATTER** if orally or parenterally): furthermore and **BECAUSE** many commercial preparations (of probiotics) at least partially contain dead bacteria/fungi, prescribe a **double-than-standard dose (DSD) of probiotics** with any systemic oral and/or parenteral antibiotic treatment: ALWAYS CONTINUE PROBIOTICS AT LEAST 5-7 days after finishing the antibiotherapy. In case of diarrhea (no matter if secondary to antibiotics/bacterial or of other etiology: viral, fungal etc.) use DSD of bacterial probiotic **PLUS** standard dose (**SD**) or DSD of fungal probiotic, except in very immunosuppressed patients where SD of bacterial (/fungal) probiotic is recommended, SO THAT to prevent a possible systemic infection with probiotics in severely immunosuppressed patients. (**FMM&FPE**)

14. **AVOID** proton-pump inhibitors and H2-antagonist antacids in children as long as possible (except when strongly indicated), because they expose the entire organism to potential dangerous bacteria and viruses by blocking the gastric acid barrier (which is an essential "immune shield"!): after vomiting for example, first use oral rehydration solutions (**ORS**) in progressively higher doses (5ml each 5 minutes initially and then 5ml each 4/3/2/1 minutes progressively), BECAUSE all ORS also contain sodium bicarbonate which also neutralize gastric acid for short intervals so that the gastric mucosa can recover more rapidly from any infectious and/or non-infectious inflammation. (**FPE**)

15. IF/WHEN a breastfeeding baby or infant is on anti-rickets preventive treatment with vitamin D3, temporarily double the vitamin D3 dose for 7 days when that child develops any respiratory/digestive/urinary infection in the meanwhile: if possible, **ALSO** add a standard-for-age oral dose of vitamin C, zinc **AND** omega-3 fatty acids in such infectious episodes, ESPECIALLY when treating underweight patients who deserve special attention and a highly protective therapeutical approach. (**FPE**)

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II. References
(partially integrated as Wikipedia URLs in the main text of this paper)

[**1**] Andrei-Lucian Drăgoi (July 2019). (ASEA in DMD - CJBRT article - 20.07.2019) **The Remarkable Effects of "ASEA redox Supplement" In A Child with Duchenne Muscular Dystrophy – A Case Report,** Canadian Journal of Biomedical Research and Technology (CJBRT) 2019; volume 1, issue 4:8. ISSN: **2582-3663.** URLs: URL1a, URL1b, URL1c (CJBRT original sources); URL2a (Research Gate source); URL2b & URL2c (Academia sources); URL2d (Vixra source); URL3 (Research Gate **preprint** source). **See also the newly released related add-on paper (RG preprint)** *The 1st case report on the remarkable effects of "ASEA Redox Supplement" (ARS) in a boy with Duchenne muscular dystrophy (DMD) – periodic updates released after 20.07.2019 (the date of the official case publication in a peer-reviewed journal)* (DOI 10.13140/RG.2.2.23141.76002, URL to RG preprint).

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[**4**] Andrei-Lucian Drăgoi (August 30th, 2019). (ASEA in DMD 2nd case preprint - v.1.0 - 30.08.2019 - 10 pages) **A Second Case Report Regarding the Effects of "ASEA redox Supplement" in a ~5-year old boy with Duchenne Muscular Dystrophy from Bucharest, Romania (preprint)**. Research Gate preprint with DOI: 10.13140/RG.2.2.18399.41128. **URL1a** (Research Gate main source), **URL1b** (Academia secondary source), **URL1c** (Vixra secondary source), **URL1d** (dragoii.com latest variant source), **URL1e** (GSJ secondary source).

[**5**] Andrei-Lucian Drăgoi (November 23rd, 2019). (Ataluren in DMD - version 1.0 - 23.11.2019 - 5 A4 pages) **A proposed extension of Ataluren indications (with future deserved studies) in patients with Duchenne muscular dystrophy (DMD) caused by frameshift mutations of dystrophin gene associated with abnormal premature termination codons (PTCs) at distance from the site of that given frameshift mutation**. Research Gate preprint with DOI: **10.13140/RG.2.2.21648.76804. URL1a** (Research Gate main source), **URL1b** (Academia secondary source). **URL1c** (Vixra secondary source), **URL1d** (GSJ secondary source), **URL1e** (**dragoii.com latest variant source**).

[**6**] Andrei-Lucian Drăgoi (February 29th, 2020). (NADS in COVID-19 - short communication - version 1.0 - 1.5 A4 pages when excluding references - 29.02.2020) **Potent NRF2-activating dietary supplements (like resveratrol, curcumin, sulforaphane, "Asea redox supplement" [ARS]) should be clinically tested as adjuvants in all types of medium and severe cases of aggressive respiratory viral infections (including Influenza A/B/C, SARS, MERS, COVID-19) based on their extrapolated cytoprotective antioxidant effects**. Research Gate preprint with DOI: **10.13140/RG.2.2.33764.12163. URL1a** (Research Gate main source), **URL1b** (Academia secondary source). **URL1c** (Vixra secondary source). **URL1e** (**dragoii.com latest variant source**).