NICE guidelines on fever in children

The NICE guidelines for Feverish illness in young children is a document that contains useful practical advice on fever care. It illustrates that when dealing with a feverish child, the issue is to exclude an underlying dangerous infection rather than treating the fever with antipyretic interventions. This gives the opportunity for every clinician to give the same confidence-building message to the public.

- Antipyretic agents (paracetamol and ibuprofen) should not routinely be used with the sole aim of reducing body temperature in children with fever who are otherwise well.
- Antipyretic agents do not prevent febrile convulsions and should not be used specifically for this purpose.
- Paracetamol and ibuprofen should not routinely be given alternately to children with fever.
- Tepid sponging is not recommended for the treatment of fever.
- Children with fever should not be under dressed or over wrapped.
- The use of antipyretic agents should be considered in children with fever who appear distressed or unwell. Either paracetamol or ibuprofen can be used to reduce temperature in children with fever. Paracetamol and ibuprofen should not be administered at the same time to children with fever.

To build confidence in parents who are caring for feverish children, it is essential that health professionals stop maintaining two medical myths, the first that fevers can get too high and death ensues, and second, that febrile convulsions happen when the temperature gets too high. These two myths are the cause for the widespread anxiety about fever. Furthermore, doctors believe that reducing the temperature makes the child feel more comfortable.

The result of the advice ‘to manage the fever’ gives parents the impression that the temperature should be reduced and is often advised as such by clinicians. However, the above bullet points illustrate otherwise. This is important because every practicing doctor in the out-of-hours service is aware of phone calls from parents who ring in a panic because they realise that they ‘cannot control the temperature’.

This iatrogenic fever phobia is a frequent cause for distress in parents, which has its effects on the child, and the health professionals who deal with the caller.

Due to the frequency of these type of calls, it puts pressure on the OOH service and the outdated advice ‘to manage the fever’ or ‘to control the fever’ is potentially resulting in a second call during the same shift when the temperature is not responding and this again is the cause for attendances to the primary care centres and subsequent contacts with the paediatric departments and admissions.

Rather than advising to fear and fight a fever, doctors can give advice that supports the fever process and, as such, build confidence in parents caring for their feverish child. Implementing this NICE advice and organising a public awareness campaign to support the fever process has the potential to create health gains for all involved and financial gains for the PCTs due to less pressure on the services.

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REFERENCE

Diagnosing depression

We have some concerns about the validity of the study by Gilbody, et al. Patients were recruited for a randomised controlled trial of collaborative care for depression in primary care. Thirty-six of 96 (93 in the abstract) patients (37.5 %) were diagnosed with major depressive disorder according to SCID. Such high prevalence indicates that patients were not randomly chosen from practices. Receiver-operating curve statistics was applied on this obviously highly-selected group of patients. This is misleading; any depression screening instrument may demonstrate excellent performance in such groups. For instruments to prove useful in general practice, statistics should be based on representative practice population samples.2–4

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