



GRANDIR Web site :

<http://www.grandir.sidaction.org/>

Grandir : Prévention et prise en charge du VIH/SIDA chez l'enfant - Mozilla Firefox

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English Version

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Bienvenue sur le site Grandir !

Bienvenue sur ce site destiné aux acteurs de la lutte contre le VIH chez l'enfant en Afrique. Vous pourrez découvrir le projet Grandir, télécharger nos publications (Lettre d'actualité Grandir, Info, fiches pratiques, outils pratiques, etc), découvrir les programmes de terrain que nous soutenons et trouver de la documentation et des liens pour tout savoir sur le VIH pédiatrique. Bonne visite !

L'équipe Grandir

LES DERNIERES ACTUALITES

Le 22/06/2010
Ouverture de la "Maison des enfants" à Kpalimé

Fruit d'un partenariat franco-togolais, la "Maison des enfants" est le premier centre médico-psychologique dédié aux enfants et aux familles touchés par le VIH au Togo.

[Lire la suite](#)

LES RESSOURCES

Derniers documents ajoutés :

Le 22/06/2010 dans Fiches pratiques : [La douleur de l'enfant : mieux la comprendre pour mieux la soulager](#)

Le 25/05/2010 dans Outils pratiques : [Affiche campagne de dépistage des pères](#)

Le 29/03/2010 dans Outils pratiques : [Bilan de l'enquête Grandir sur la disponibilité des sév pédiatriques et de la PCR pour les enfants exposés au VIH et infectés par le VIH en Afrique](#)

GRANDIR INFO

A newsletter on paediatric HIV in Africa

A newsletter on paediatric HIV in Africa



N°27 April-may 2010

in focus Measuring malnutrition in a cohort of HIV-exposed newborns fed Infant Formula in West Africa

Growing Up program studied weight progression in children enrolled in nutritional support programs that are funded by Growing Up to evaluate these programs' impact. The study's goal was to determine the prevalence of malnutrition in a cohort of 88 newborns under a year old that were being fed infant formula from 0 to 12 months of age and receiving fortified flour from 7 to 12 months (the infant formula and fortified flour were donated by the Growing UP program). These babies were monitored at a community HIV health center and the study was conducted in real life conditions with monitoring data collected by caregivers between March 1, 2007 and December 5, 2008 (this was neither operational research nor a planned study with a protocol designed in advance).

The overall analysis was based on WHO's weight for age index. The longitudinal index of WIA of three sub-groups of children— infants enrolled in the program during their first weeks of life, infants enrolled during weaning and babies suffering from malnutrition at enrollment were also observed. We analyzed a total of 473 of WIA measurements corresponding to 520 food distributions. Each measurement was compared to the 2006 WHO standards. A cohort was created in the WHO Anthro software and completed with Excel.

The main results of the study are:

Infants' conditions when they were enrolled in the study according to age category:

0-3 month old infants
23 infants in their first trimester of life were enrolled, 21 were weighed before receiving nutritional support; 7 (31%) had a WIA <-3 DS which corresponded to acute malnutrition or delay in intra uterine growth (Intra Uterine Growth Retardation-IUGR) or prematurity; 3 (14%) had a WIA between -3 and -2 DS, or 47% who presented a WIA ratio indicating pathology.

3-6 month old infants
29 infants were enrolled during their 2nd trimester of life, 27 were weighed before receiving nutritional support; 2 (7%) had a WIA of -3 DS (and even <-4 DS); 6 (22%) had a WIA between -3 and -2 DS, or 30% who presented a WIA indicating pathology. However, severe malnutrition was clearly less prevalent.

6 to 9 month old infants
32 infants were enrolled during their 3rd trimester of life, 31 were weighed before receiving nutritional support; 5 (16%) had a WIA <-3 DS; 5 (16%) had a WIA <-2 DS, or 32% who presented with a WIA indicating pathology.

Babies over 9 months of age
4 babies were enrolled between 9 and 10 ½ months of age, 3 presented with a pathological WIA.

in focus Measuring malnutrition in a cohort of HIV-exposed newborns fed Infant formula in West Africa

new/briefs
5^e Francophone Conference on HIV/AIDS: report back on sessions on paediatrics

new/briefs
Maternal health and responding to HIV: same struggle!

etcetera
Results of the cartoon bubble and slogan contest

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Thank you to the GROWING UP technical committee for their advice and editing.

GRANDIR's practical information fact-sheets in french and english

★★ N° 19 Medical care and treatment

The child with pain: better understanding for better relief



Case Study

Mohamed, 6 years old, was seen in consultation a few days ago with a febrile oral fungal infection. He was prescribed an antifungal treatment. Three days later he returns. He is dehydrated, refuses to take the treatment, refuses to eat, is completely uncooperative and fearful when you come near him.

What do you think about these symptoms and how do you approach this consultation?

Paediatric AIDS, a painful illness

As in adults, there are many causes of pain in HIV-infected children: bacterial infections (meningitis, respiratory distress, skin and oral infections, etc.), encephalitis, abdominal pain (pancreatic, oesophageal, uncontrollable diarrhoea, partial occlusions; various mechanisms and causes sometimes difficult to diagnose), diffuse bone and joint pain especially in advanced AIDS with wasting.

Depending on how early the child has been taken into care, he or she may have had numerous traumatic experiences of pain.

Added to the pain associated with complications is the pain related to drug side effects (headaches, neuropathies, abdominal pain) and caused by various health care procedures (needles, dressings, etc.).

These different pains have been rarely described and studied and there are no guidelines in existence; in clinical practice, pain is infrequently asked about and assessed. Finally, pain in children is not adequately taken into account. Nevertheless, by following a few basic principles and using simple analgesics, it is possible to minimise pain, in particular those associated with procedures.

Symptomatology of chronic pain: early onset in children

Chronic pain in an adult is defined as pain that has persisted for longer than 3 to 6 months. In infants and young children, overt manifestations of acute pain (crying, agitation) may be replaced by signs of chronic pain after just 48 hours. The child then presents

more discrete signs, a varying combination of the following: psychomotor atonia, maintaining of an antalgic posture, moaning, repeated demands to change position, asking to eat but unable to swallow, crying when an adult approaches, even total loss of all verbal communication and hyperaerousal (localisation of the child on his pain which increases pain sensation).

Pain due to excessive painful stimuli, neuropathic pain, psychogenic pain: different mechanisms for which the therapeutic approach is not identical

Different mechanisms may be implicated in the process of pain production. They are sometimes combined. It is important to recognise them since each is treated differently.

- Pain caused by an excess of painful stimuli (nociceptive pain): a typical example is an undisplaced fracture. There is tissue damage and local inflammation which stimulate certain nerves and send pain messages to the brain.
- In neuropathic pain, the nerve tissue itself (peripheral nerve or central nervous system) is damaged and a non-painful stimulus can lead to an unpleasant sensation (prickling, electric shock) or pain. This type of pain is seen after shingles, encephalitis and in neuropathies associated with ARV drugs.
- In psychogenic pain, no organic cause can be found and there is often a traumatic psychological context. This type of pain can be incapacitating and is more difficult to manage.

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The different types of analgesics

For nociceptive pain, classic analgesics are used. Paracetamol and ibuprofen (step 1 of the WHO pain relief ladder) can be used together and given alternately. If these prove ineffective, they can be combined with step 2 analgesics. Codeine can be given from the age of 1 year. Codeine is metabolised in the liver and 10% of the dose is transformed into morphine. It can be found alone (e.g. Galcodine paediatric linctus) or combined with paracetamol (combine forms) can be used from the age of 2 years on. The alternative to codeine is tramadol (can be used in drop form from age 3).

For more intense pain, morphine and its derivatives (step 3 of the WHO ladder) should be proposed. There is no risk of dependence (either in the short or long term) when morphine is prescribed to a child in pain. Morphine can be administered in oral (rapid- or sustained-release), injectable or patch form.

For neuropathic pain, other drug classes should be prescribed. Tricyclic antidepressants (amitriptyline, after age 4), benzodiazepines (Clonazepam) and gabapentin may be used. Neuropathic pain is not a classic indication for use in children, since drug laboratories have not taken the time to submit marketing authorisation applications (MAA) for children, owing to the small number of children concerned. However, numerous studies have demonstrated the efficacy of these drugs, for which the side effects are similar to those seen in adults. They should be proposed when neuropathy is present (as well as changing the ARV and other drugs causing the neuropathy), in cases of encephalitis and nerve involvement (shingles - Herpes zoster). Dosages are increased progressively over several days or weeks until an effective dose level is attained.


Psychogenic pain is sometimes quite incapacitating, and often difficult to treat. Organic causes must first be excluded. A multidisciplinary management strategy (personnel involved in the child's treatment, psychologist as well as social worker and counsellors) is indispensable and the cultural and family context must be taken into account. Indeed, the child may feel and present symptoms that reproduce the manifestations of pain he or she has observed in the family setting (joint pain in a child whose father has injured his legs in an accident, chest pain after the death of a grandfather or myocardial infarct, for example).

For these different types of pain, in addition to drug treatment, massage and local applications of topical anaesthetics or poultices may bring real relief when carried out or applied by competent individuals. Psychological care occupies an important place in the management of chronic pain, whatever the type.

How to assess pain in children

Self-report

From the age of 4-7 years on, visual pain self-assessment scales can be used. The child is asked to indicate on a scale of 1 to 10 "how much it hurts". This assessment should be carried out before the administration of analgesics and 1 hour afterwards. The analgesia is judged effective if the score is less than or equal to 3.




VAS: Visual Analogue Scale

- From 0 to 1 Simple discomfort
- From 1 to 3 Slight pain
- From 3 to 5 Moderate pain
- From 5 to 7 Intense pain
- From 7 to 10 Very intense pain

From 4 to 6 years, the VAS can be combined with a non-numerical scale, such as the faces pain scale, for example.

The front of the scale corresponds to the side the child is shown.



The back of the scale corresponds to the side the doctor sees.

"Show me which face has a pain like yours."

Using the scale of faces:

These faces show how much you can ache. This face (show the one on the left) shows someone who doesn't feel any pain. These faces (show the one by one from left to right) show someone who feels the pain little by little, until we get to this one (show the one on the right) that shows someone who dreadfully aches.

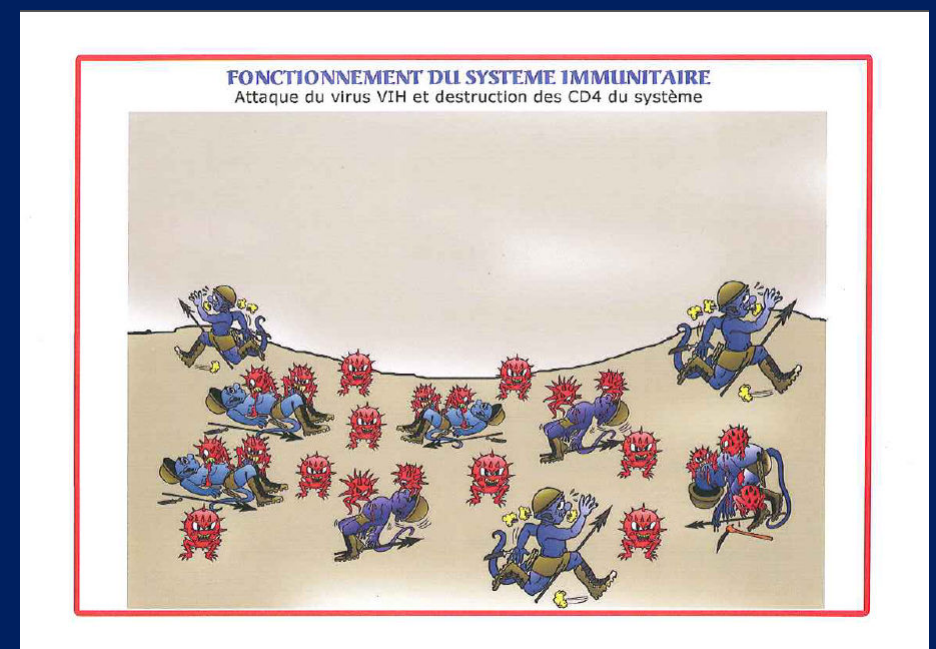
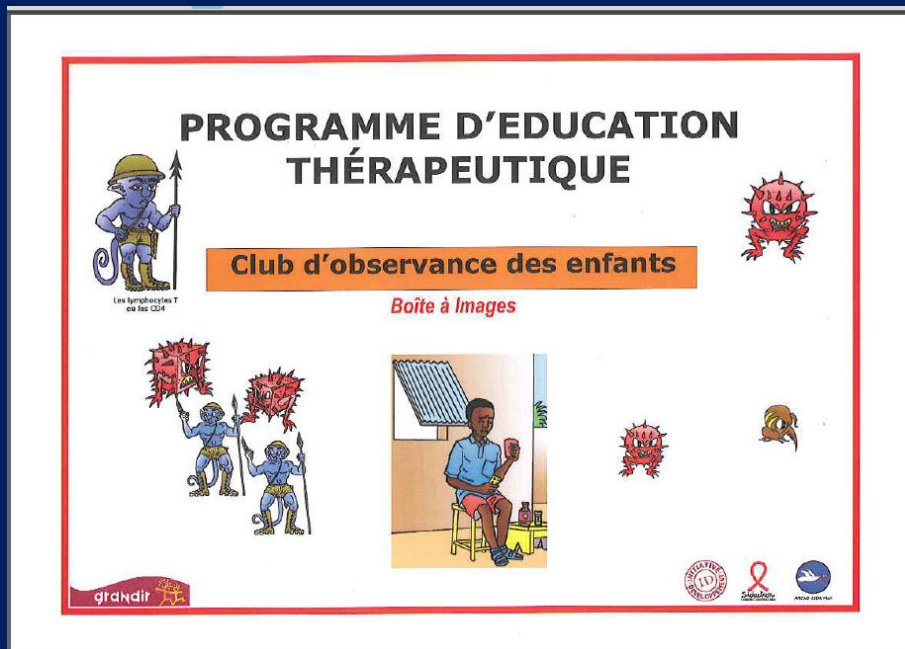
Show me the face that explains how the pain you feel is like.

The scores go from left to right: 0, 2, 4, 6, 8 and 10.

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Toolkits

For example : Visual Box for therapeutic literacy





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