5th Europaediatrics * 23-26 June 2011
Deadline for abstract submission is fast approaching!

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Excellence in Paediatrics 2010
Report from London
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Dear Colleagues and Friends,

The present issue marks two years of the existence of the EPA/UNEPSA newsletter. It has some interesting news for our growing family of European pediatricians.

First, it is necessary to comment on the great success of the Excellence in Pediatrics conference in its London edition a few days ago. The way in which the subjects were treated is the one with proven efficacy to update medical knowledge. Later on I will refer to how the evidence based way of thinking has improved our diagnosis and treatments. However, the educational programme will continue with a steady but firm path through a series of courses starting at the end 2011. In the line of education and visibility the totally renewed website (www.epa-unepsa.org) will offer static information about EPA and also a dynamic section to update clinical facts, focusing on the new concept of “working and learning together”. You will see this in February 2011.

The rhythm of the Council continues at the usual pace: renewal of Council members, the creation of an Ethics Committee and a new frame for the relation with our organizational company that ensures a continuity of Europaediatrics at the same or higher structural level than at present. This also allows the confident support status needed for a scientific society with a real and visible independence as is EPA. To directly reach any member of the Council it is enough to simply send an e-mail (epa-unepsa@candc-group.com) and you will get a personalized answer from him/her or the Council. You can get in touch with the Newsletter in the same way.

Finally, I would like to comment on our liaison with Cochrane. Please, read the section in this issue about the Research Project by Cochrane Child Health Field. Then, go to the examples and complete the on-line survey. In this way you will become more familiar with the evidence-based terms and results and you will have contributed to identify new subjects that can be of general interest in pediatric health.

Lastly, do not forget the 5th Europaediatrics congress in Vienna, the programme is cool and so will be the atmosphere there!

Manuel Moya
Editor of Newsletter

P.S. If you wish to receive an e-alert for new issues, all you have to do is send an e-mail to epa-unepsa@candc-group.com
Updates on the 5th Europaediatrics Congress

The 5th Europaediatrics 2009 is 6 months away and the excitement is rising! The Europaediatrics congress is the highlight of the activities of EPA/UNEPSA and aspires to be the meeting point of paediatricians not only from Europe but from all over the world. The 5th Europaediatrics follows the past congresses of EPA/UNEPSA held in Rome (2000), Prague (2003), Istanbul (2008) and Moscow (2009).

The activities of the flagship event of EPA/UNEPSA are coherent with and consequent to the following mission points of the Constitution of EPA/UNEPSA:

• To improve the quality of paediatric patient care in all European countries
• To stimulate collaborative research in paediatrics in Europe
• To encourage cooperation between National Paediatric Societies in Europe and between paediatricians working in primary, secondary and tertiary paediatric care in Europe
• To promote the exchange of national experiences in the various fields of patient care and make national practices known to others.

Scientific Programme

The scientific programme of the 5th Europaediatrics, addresses to paediatricians involved in primary and/or secondary care and other specialists and professionals involved in child and adolescent care in Europe. In the context of 5th Europaediatrics, various authoritative international societies and associations will share the scientific organization of Symposia and interactive Courses with EPA/UNEPSA:

• Advanced Paediatric Life Support Working Group
• Cochrane Collaboration
• European Medicines Agency
• European Society for Paediatric Endocrinology
• European Society for Paediatric Gastroenterology,
• Hepatology and Nutrition
• Paediatric Nursing Associations of Europe
• Thalassaemia International Federation

The Preliminary Scientific Programme is now available on the official website of the congress. Discover the topics that will be covered in the congress and start planning which sessions you wish to attend.

Abstract Submission

The deadline for the submission of your abstracts is shortly due. You may submit your abstracts until 10 March 2011. Don’t miss the opportunity to present your work in the largest European paediatrics congress. All accepted abstracts will circulate as a supplement in Evidence-Based Child Health: A Cochrane Review Journal, the official journal of EPA/UNEPSA. Check out in the official website the simple procedure you need to follow in order to register and submit an abstract.

The Host City and the Congress Venue

The city of Vienna will host the 5th Europaediatrics as the Austrian capital is an excellent location for an international medical congress. It is a city rich in culture, with all the modern amenities, and boasts an impressive history in the medical sciences.

Vienna is located in the heart of Europe, and is easy to reach by plane, train or car. The city offers an excellent conference infrastructure and the highly professional services required to organize the 5th Europaediatrics.

The congress will be held in the Austria Center Vienna (ACV), the largest conference center in Austria and one of the largest and most modern of Europe. ACV is located between the tower blocks of the Donau City district and the Vienna International Centre (U.N.), in the most modern part of Vienna.

Important Dates

Deadline for abstract submission: 10 March 2011
Deadline for early registration: 10 March 2011

For regular updates about the congress please visit: [www.europaediatrics2011.org](http://www.europaediatrics2011.org)

The 5th Europaediatrics features an impressive list of organising and scientific committees whose presence guarantees the success of the upcoming congress.
Updates on the 5th Europaediatrics Congress

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Secretary
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Respiratory Medicine Sessions presented in the context of Excellence in Paediatrics

A report from London

One thousand paediatricians from all over the world had the opportunity to attend the second Excellence in Paediatrics conference in London from 2 till 4 December 2010.

Along with selected centres of excellence in paediatric care, EPA/UNEPSA and the Cochrane Child Health Field presented a number of respiratory medicine sessions within the context of Excellence in Paediatrics. These special sessions took place on Saturday, 4 December 2010 in London and focused on significant respiratory issues and updated delegates upon prevention, medication and treatment.

EPA/UNEPSA was an official supporter of this prestigious international paediatric conference and was present at the exhibition area of the conference with a booth promoting the future events and initiatives of the Association.

Special interviews with top notch speakers, webcasts of selected sessions as well as speakers’ presentations and snapshots from the entire conference will be available soon through www.epa-unepsa.org and the conference’s website www.excellence-in-paediatrics.org.

Save the dates for the 3rd edition of Excellence in Paediatrics which will take place in Istanbul, Turkey on 1-3 December 2011.

**EPA/UNEPSA Council Meeting & General Assembly**

On the sidelines of the scientific meeting in London, EPA/UNEPSA held a Council Meeting and the General Assembly. The representatives of the member societies that attended the Assembly contributed with their votes to define the direction and the immediate steps for the European Paediatric Association.

The tenures of two Council members were renewed after holding elections on Saturday, 4 December 2010. The Council that currently leads the Association has the following composition:

- A. Konstantopoulos, President (term ends in 2011)
- M. Pettoello-Mantovani, Secretary General (term ends in 2011)
- A. Baranov, Vice-President (term ends in 2011)
- M. Moya, Vice-President (term ends in 2012)
- J. Ehrich, Treasurer (term ends in 2011)
- F. Çullu Çokuğraş, Councilor (term ends in 2012)
- L. Szabó, Councilor (term ends in 2011)
- A. Rubino, Past President
- W. Kaulfersch, Ex-officio member, President of the 5th Europaediatrics 2011

The Council and General Assembly adopted a number of principles on the association’s ethical conduct and an initiative to organise additional educational activities as of 2011. In addition, EPA/UNEPSA has embraced 2 new members, the Romanian Society of Pediatrics and the Romanian Society of Social Paediatrics, reaching now the number of 40 member societies.
European Paediatric Association (EPA/UNEPSA)

Join the most extensive paediatric network in Europe!

Since the launch of the individual membership scheme, the European Paediatric Association (EPA/UNEPSA) embraces a constantly increasing number of individual members from all over Europe.

EPA/UNEPSA welcomes all doctors who are certified as paediatricians in Europe and are members of their respective National Paediatric Society/Association participating in EPA/UNEPSA.

By joining EPA/UNEPSA, you gain access to a network of 38 national European associations and open yourself to a new world of opportunities.

Benefits
The individual membership is offered at a privileged 50 Euro annual fee and encompasses a set of benefits that aim to provide value to the wide community of European paediatricians.

• On line access to the Evidence Based Child Health Journal is a core benefit of individual membership to our association and we are excited by the prospect of making such a valuable resource widely available to paediatricians across Europe.

• Our members will enjoy reduced registration fees to Europaediatrics as well as to other events organised by our Association.

• The quarterly newsletter aims to be a source of current information relevant to the interests of European paediatricians.

• Finally, our members will find in our website a valuable tool and resource (access to the members-only section, on-line directory of members, complimentary or privileged prices for additional on-line services).

Individual membership is offered on an annual basis starting on the 1st January of each year and ending on the 31st of December.

You may apply on line for an individual membership. Please visit our website www.epa-unepsa.org for more details and to fill out a registration form.

We look forward to welcoming all of you in EPA/UNEPSA!
Vomiting is a common symptom of acute and chronic illness in childhood. It is a coordinated event usually preceded by nausea in association with increased salivation, gastric atony, and reflux of duodenal contents into the stomach, resulting from non-peristaltic contractions of the small bowel. In the diagnosis and management of nausea and vomiting in childhood, age of presentation and chronicity of symptoms are both important clinical features to assess.

In many countries it is not unusual that general practitioners (GP) are the first professionals consulted by the families or caregivers to check a vomiting child. Therefore, is important for them to resolve few key questions useful both for a correct management of the symptom, and for taking the correct decision on whether to refer the vomiting child to a pediatric specialist.

Key clinical questions

Should the presentation of vomiting be acute, the general practitioner needs first to ask himself whether the child have a cause other than infective gastroenteritis. A second important question regards the child hydration and it is whether there is any reason why oral rehydration is not appropriate and also whether the child needs admission to hospital for nasogastric or intravenous rehydration. If symptoms have been present for weeks or months, the GP needs to consider whether the child is failing to thrive and conclusively whether the child requires referral for specialist investigation.
Vomiting management in children
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Additional red flag symptoms requesting immediate hospital evaluation and management are: high fever, abdominal distension and/or tenderness, persistent tachycardia or hypotension, neck stiffness and/or photophobia.
A special attention must be devoted to vomiting children with chronic illness, poor growth and infants less than 6 months of age. In such population a cautious evaluation of both differential diagnosis and hydration status must be performed.

Infants and children presenting with chronic vomiting: diagnosis to be considered

Vomiting is a quite common feature of early infancy. In particular, vomiting together with regurgitation and rumination are symptoms suggestive of gastroesophageal reflux, which may evolve in gastroesophageal reflux disease due to possible tissue damage (oesophagitis, obstructive apnoea, reactive airway disease, pulmonary aspiration, or failure to thrive).
During the first year of life congenital gastrointestinal anomalies such as malrotation can be present and food allergies are a frequent evidence at the time of first introduction of the offending antigen into the infant's diet. In the older child vomiting is frequently preceded by nausea.
Differential diagnosis of chronic presentations of vomiting in the older child include gastroesophageal reflux, gastritis and cyclical vomiting, and specialist referral is usually necessary for further investigation which may include endoscopy or consideration of nongastrointestinal causes of vomiting such as raised intracranial pressure or inborn errors of metabolism.

Infant regurgitation: first, establish the difference with vomiting

Infant regurgitation is defined as the passage of refluxed gastric content into the oral pharynx, whilst vomiting is defined as expulsion of the refluxed gastric content from the mouth.
Regurgitating infants usually present such event two or more times per day for 3 or more weeks in the first 1–12 months of life in an otherwise healthy infant. In these children, associated features of retching, haematemesis, aspiration, apnoea, failure to thrive, or abnormal posturing suggestive of a metabolic disorder (for instance galactosaemia), other gastrointestinal disease, or central nervous system disease are absent to explain the symptom. However, it is important to consider congenital obstruction of the gastrointestinal tract in infants presenting with vomiting in the first week of life, particularly if bile stained.
As infant regurgitation is a physiologic and transient event possibly due in part to the immaturity of gastrointestinal motility, parental education and reassurance are of primary importance in its management, along with lifestyle changes, including appropriate prone positioning after meals, the use of thickened formula and smaller volume feedings. However, although dietary treatment could be considered a first-line approach, it must be taken in consideration that the misuse of hypoallergenic and thickened formulas could lead to nutritional impairment. Regurgitating infants should undergo appropriate follow-up.

Gastroesophageal reflux and gastroesophageal reflux disease in vomiting children: when to think about it

Gastroesophageal reflux (GER) is the passage of gastric contents into the esophagus with or without ejection of contents from the mouth due to regurgitation or vomiting. GER is a normal, physiologic process which can occur several times per day in healthy infants, and to a lesser frequency in children, and adults. GER in healthy infants does not need treatment. GER is a normal physiologic process that occurs several times per day in healthy infants, children, and adults. Approximately 50% of normal 3- to 4-month-old infants regurgitate at least once per day and it is reported that an elevated number of caregivers in economically advanced countries seek medical help for this normal behavior (1).
Gastroesophageal reflux disease (GERD) is identified by the presence of troublesome symptoms and/or complications of persistent GER.
A diagnosis of GERD should be considered in the presence of different symptoms and signs, including failure to thrive, haematemesis, occult blood in the stool, anaemia, or refusal to eat, and requires referral to a specialist for more formal investigation which may include 24 hour pH-impedance monitoring and/or gastroscopy.

**Cow’s milk protein allergy in vomiting children: when to think about it**

Vomiting and irritability may be symptoms associated to Cow’s milk protein allergy (CMPA), a condition which affects 2-7.5% of infants below 24 months of age in economically advanced countries and is the most common form of food allergy in this age group. It is of great importance, though not always easy, to differentiate CMPA from a syndrome of benign regurgitation and colic. Both regurgitation and colic are by definition not caused by organic disease. Diagnostic criteria of infant colic include paroxysms of irritability or crying that start or stop in absence of a clear cause, usually last more than three hours per day and occur at least three days per week.

Colic spontaneously resolves by the 4th month of age and is not associated with failure to thrive, while regurgitation usually recede gradually during the first 12 months of life and frequently improves either at the time of introduction of solid food or when the child begins to walk (2).

It is important to consider that intact cow’s milk proteins, such as beta-lactoglobulin and alpha-lactalbumin, are secreted in breastmilk, therefore CMPA is not limited to formula fed infants.

In children with CMPA, it is usual to observe the allergic response developing within four weeks of starting cow’s milk formula. In case CMPA is suspected, a trial of formula change is the standard.

Symptomatic infants with no alarm symptoms (mild-to-moderate manifestations) should receive an extensively hydrolysed formula (eHFs), or amino acid-based formulae (AAF) if the infant refuses to drink eHF or if the cost–benefit ratio favors AAF, for at least 2–4 weeks. Children who show a substantial improvement or disappearance of symptoms should undergo a challenge under medical supervision. If symptoms of CMPA emerge upon food challenge, the child should be maintained on eHF or AAF for at least 6 months or until 9–12 months of age. If symptoms do not improve on eHF, primary care physicians and general pediatricians should consider an elimination diet with AAF, other differential diagnoses or both for the symptoms and/or refer the patient to a pediatric specialist (3,4).

**The use of soy protein formula and other alternative milk.** Soy protein formulae can be used for feeding term infants, but they have no nutritional advantage over cows milk protein formulae and contain high concentrations of phytate, aluminum, and phytoestrogens (isoflavones), which might have untoward effects. Soy protein formulae have no role in the prevention of allergic diseases and should not be used in infants with food allergy during the first 6 months of life. If soy protein formulae are considered for therapeutic use in food allergy after the age of 6 months because of their lower cost and better acceptance, tolerance to soy protein should first be established by clinical challenge since 30 to 50% of infants given a soy formula for the management of CMPA are reported to develop an allergic reaction (5). There is no evidence supporting the use of soy protein formulae for the prevention or management...
of infantile colic, regurgitation, or prolonged crying (5). However, in infants over six months a trial of formula change may include infant soy formula for two weeks. If improvement is not noted following a 2 week trial of soy formula, then specialist referral is warranted to assess whether progression to extensively hydrolysed formula is required.

**NOTE:** the use of partially hydrolysed formulae or the unmodified mammalian milk protein, including unmodified cow’s, sheep, buffalo, horse or goats’ milk, or unmodified rice milk, is not recommended for infants. These milks are not adequately nutritious to provide the sole food source for infants. Furthermore, the risk of possible allergic cross-reactivity means that these milks or formulas based on other mammalian milk protein are not recommended for infants with suspected or proven CMPA (5).

**Children with CMPA: vomiting and other signs and symptoms**

Cow’s milk protein allergy can induce immediate reactions (vomiting, perioral or periorbital oedema, urticaria, or anaphylaxis) occurring several minutes to two hours after the initial ingestion of cow’s milk protein. Skin prick testing (SPT) and/or measuring food specific serum IgE antibody levels (RAST testing) reveal the IgE mediated nature of immediate reactions to the introduction of cow’s milk protein. By contrast, late CMPA reactions, including vomiting, diarrhoea and severe irritability, take place within several hours to days of newly introduced cow’s milk protein and are often difficult to diagnose. In these cases, to consult with a specialist is advisable since reactions are usually SPT negative and elimination or challenge protocols are required to make a definitive diagnosis. Food allergy forms due to non-IgE mediated reaction are not associated with anaphylaxis. Referral to a specialist is recommended in a vomiting infant with suspected CMPA who has failure to thrive or bloody diarrhoea. Infants with evidence of immediate reactions to CMPA suggestive of IgE mediated food allergy should be urgently referred to a paediatric allergist for SPT.

**MANAGEMENT OF THE ACUTELY VOMITING CHILD**

Dehydration is a frequent finding in vomiting children. To establish an effective management it is vital to assess the degree of dehydration, since inaccurate assessment of dehydration can have important consequences, such as a delay in administering urgent treatment, or overtreatment with unnecessary interventions.

Conventionally, patients are classified into subgroups for minimal or no dehydration (<3% loss of body weight), mild to moderate dehydration (3%–9% loss of body weight), and severe dehydration (>9% loss of body weight) (6, 7).

However, degrees of dehydration relate to clinical signs and change in body weight if a recent reliable weight is available. There are no specific clinical signs associated with mild dehydration (<3% body weight loss). First signs of dehydration may not be evident until 3 to 4% of body weight loss, with more numerous clinical signs evident at 5% dehydration. Moderate dehydration (3–9% body weight loss) is best assessed by decreased peripheral perfusion, decreased skin turgor (pinched skin retracts slowly 1–2 seconds) or evidence of deep acidotic breathing. Sunken eyes and dry mucous membranes may also indicate dehydration, although these signs should not be relied upon as they are highly variable. Signs indicating severe dehydration may not be evident until fluid loss >9% of body weight. Because of this threshold effect, it may be difficult to distinguish between mild and moderate dehydration based on clinical signs alone.

Severe dehydration >9% of body weight loss are more pronounced and include sweaty, cyanotic limbs, rapid weak pulse and low blood pressure. The child with vomiting should continue to be fed (including breastfeeding as appropriate) unless severely dehydrated. Most children can be rehydrated with oral or nasogastric feeds unless they have severe dehydration, in which case intravenous resuscitation is essential (8).
Some common sense for clinical management of dehydration in vomiting children:

- Laboratory studies should be limited to those necessary to guide management.
- No unnecessary medications should be used.
- Antiemetic medications are not recommended in a child acutely presenting with vomiting as they are unlikely to be effective and may be harmful.
- Breast-fed infants should continue nursing on demand and those on formula should continue their usual formula as soon as rehydration is achieved in amount sufficient to satisfy energy and nutrient requirements.
- Lactose-free or lactose-reduced formulas are usually not justified. In fact, although medical practice has often favoured beginning feeds with diluted formula, such as half or quarter strength, no sufficient evidence exist supporting such practice.

Management of children with mild dehydration

For those mildly dehydrated infants and children, treatment is aimed at replacing ongoing losses. And they should be encouraged to increase the frequency of their usual drinks. However, undiluted commercial ‘soft drinks’ should be avoided as they present a significant osmotic load to the intestine which can result in increased vomiting and/or diarrhoea. To ensure optimal management at home, parents should be given advice.

Written handouts are useful to reinforce key messages to carers, which should include encouraging regular fluid intake even if the child continues to have vomiting or diarrhoea. Oral rehydration solution (ORS) can be given in addition to breastfeeding. If the infant is bottle fed, clear fluids or ORS should be offered for the first 2 hours and then normal formula in small but more frequent amounts. 1 mL ORS for each gram lost to vomiting or diarrhoea or 10 mL/kg for each diarrhoeal stool, 2 mL/Kg for each episode of emesis. There is no need to restrict food. Daily review by the GP is appropriate until initial evidence of symptomatic improvement, although babies under 6 months of age with gastroenteritis may need more frequent review in the early stages of the illness.

Parents should be advised to be in touch promptly if the child has significant diarrhoea (showing more than 8–10 watery motions per day), refuses to drink, has vomiting or diarrhoea continuing after 1 week, or there is evidence of significant dehydration such as few wet nappies, pallor, peripheral shut down or drowsiness. Finally, it is important to inform parents that significant abdominal pain requires urgent evaluation.

Management of children with moderate dehydration

If the child is moderately dehydrated and able to tolerate fluids then a trial of ORS is appropriate. In particular, ORS 50-100 mL/kg over 3 to 4 hours is indicated to replace estimated fluid deficit, with additional ORS given to replace existing losses. Although WHO guidelines recommend a maximum rate of 20 mL/kg, the rate may be individualized.

Small volumes of fluid should be offered initially by using a teaspoon, syringe, or medicine dropper, gradually increasing the administered amount as tolerated. It is safe to give ORS very rapidly and frequent, small bolus feedings will be generally better tolerated than larger boluses which may increase vomiting.

In case a child requests a volume of ORS greater than estimated, more can be offered. If the child is unable to tolerate fluids then admission to hospital and placement of a nasogastric tube is a safe and effective way to rehydrate most children with moderate dehydration, even if the child is vomiting.

Management of children with severe dehydration

Severe dehydration represent a medical emergency. In fact, admission to hospital is requested for any child with severe dehydration, and immediate rehydration
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until circulation is restored either through intravenous or intra-osseous access. Urgent electrolytes, glucose, FBC, blood gas and urinalysis should be considered as well as consideration of the need for septic work up or urgent surgical consult.

Summary: key points in evaluating a vomiting child

Key points for a general evaluation of vomiting children are listed in the table below.

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<td>1. In a child presenting with an acute episode of vomiting, always consider other diagnoses before orienting to a viral gastroenteritis. Especially if the subject show haematemesis, bilious or projectile vomiting, abdominal tenderness, high fever or meningism.</td>
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<tr>
<td>2. The child with chronic presentations of vomiting should be referred to a specialist for careful assessment if there is evidence of failure to thrive, symptoms suggestive of cow’s milk allergy or gastroesophageal reflux disease or in the older child with unremitting symptoms</td>
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<td>3. Mild dehydration can be managed at home</td>
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<td>4. Moderate dehydration may require referral to a specialist and admission to hospital pediatric unit for nasogastric tube rehydration if oral fluids are not tolerated</td>
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<td>5. Severe dehydration requires urgent admission to hospital pediatric unit for intravenous hydration and treatment of shock</td>
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It is not unusual that children with mild and moderate dehydration will fail to improve with ORT, therefore it is meaningful to observe dehydrated children until signs of dehydration recede. Hydration status should be reassessed on a regular basis, with more frequent monitoring given to the children whose status is more fragile. Such assessment may need the consult with a specialist and can be carried out in an emergency room, office, or other outpatient setting.

REFERENCES

The Republic of Croatia is a country with 4.4 million residents, 840,000 of which are children up to 18 years old. The indicators of children’s health care are good: perinatal mortality is 4.6/1000 of born altogether of birth weight ≥1000 g, while the mortality of infants is 4.5 in respect to 1000 liveborn infants. All children in Croatia up to 18 years of age have national health care insurance. Primary pediatric care includes around 75% of children, and the others are included in health care provided by family doctors. In secondary and tertiary care there exist 23 children departments within general hospitals, 3 children hospitals and 4 pediatric departments within university hospitals.

The first educated pediatrician in Croatia was Radovan Marković. In 1904 he founded the first Children’s Department in hospital “Sestre milosrdnice” in Zagreb. Already in 1903 he wrote, for that time a very modern manual “Children’s care: instructions for a young mother”. In 1923 the Department of Pediatrics at Medical School in Zagreb was established. The first Head of the Department of Pediatrics was Professor Ernest Mayerhofer. He wrote the first manual on pediatrics in 1925, and in 1939 he wrote the textbook “Pediatrics”. Professors Marković and Mayerhofer are well known for their social work and their support to educating people on health care. Thus they were writing about children’s health care and trying to actively implement regulations on children’s health care. The pediatric ambulatory services have been established in 1908 when Dr. Žiga Švarc founded the Children’s Clinic in Zagreb. From that day on, the ambulatory services in Croatia have been implementing children’s and mother’s primary health care and have considerably contributed to improvement of children’s health care.

Linking pediatricians in Croatia was formally organized in 1930 when Professor Mayerhofer established the Section of Croatian Pediatricians within the Croatian Medical Association. Since then the Section has been continuously working until year 1993 when the Croatian Pediatric Society (CPD) has been founded. The first president of CPD was Professor Duško Mardešić. The duties of CPD are as follows: development of children’s health care, professional and scientific improvement, organizing professional congresses, collaboration with other professional societies, cherishing medical ethics, controlling health care measures and providing professional opinions. Besides CPD, 8 subspecialist pediatric societies (neurology, endocrinology, gastroenterology, nephrology, cardiology, pulmology, preventive/social pediatrics and immunology) and three sections (metabolism, intensive medicine and neonatology) are active in Croatia. All the subspecialist pediatric societies and sections organize their annual national symposia.

CPD organizes congresses regularly, every two years, always together with the Society of Pediatric Nurses. So far, nine Congresses of CPD have been held. In this newsletter issue we have prepared a special report on the Congress of CPD, held in October 2010. Besides, every year CPD holds the symposium “Croatian pediatric school”. The symposium includes eminent Croatian and foreign experts, who give instructions to professionals on actual problems regarding various fields of pediatrics.

CPD also has a well organized web page (www.hpd.com.hr). The page contains various news, notifications on congresses in Croatia and abroad, and recommendations from CPD. Besides, it provides the possibility of organizing discussion
groups and sending announcements to all Croatian pediatricians.

Today there are 606 active pediatricians in Croatia, 236 of which are in primary care. In larger cities the children's healthcare relies on pediatrician, but in smaller places there is a lack of pediatricians in primary care. The majority of pediatricians are women (78%). Distribution by age is adverse, only 23% of pediatricians is younger than 44. However, the number of pediatric residents in the last 5 years increased from 78 to 165, thus we expect a significant improvement in age structure of pediatricians over the next few years.

Croatian pediatricians publish more than 100 scientific papers per year, 40 of which find their place in journals quoted in Current Contents. The journal Paediatrica Croatica, that was first published in 1958 by the name of "Arhiv za zaštitu majke i djeteta" (Archives for Mother and Child Protection), helps scientific work to a great extent. The journal Paediatrica Croatica publishes papers in Croatian and English language, thus we invite all the European pediatricians to collaborate with us and submit their manuscripts. Paediatrica Croatica is indexed/abstracted in: Thomson Scientific, Embase/Excerpta Medica, Amsterdam, Index Copernicus, Journal Citation Reports/Science Edition, Science Citation Index Expanded (SCIE), Abstracts Journal, All-Russian Institute for Scientific and Technical Information (VINITI), Scopus, Google Scholar, and Scientific Commons. The journal’s web page is www.paedcro.com.

CPS is a member of European Pediatric Association (EPA/UNEPSA), International Pediatric Association (IPA), Union of Middle-Eastern and Mediterranean Pediatric Societies (UMEMPS) and an associate member of European Academy of Pediatrics (EAP). Professor Josip Grgurić was a member of the EPA Council. CPD’s members actively participate in international association's activities, especially the EPA’s. Therefore, at the 5th Europaediatrics congress that will be held in Vienna in June 2011, we expect the usual numerous attendance of Croatian pediatricians, while three Croatian pediatricians are going to participate at the Congress as lecturers. Moreover, the EPA plans to organize a workshop in 2011 in Split on emergencies in pediatrics.

Professor Julije Meštrović
President of Croatian Pediatric Society

Professor Josip Grgurić
Member of Executive Board of Croatian Pediatric Society

History of the Croatian Pediatric Society

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History of the Croatian Pediatric Society
Dear Paediatrician,

At the Cochrane Child Health Field, we are testing a format of summarizing and presenting evidence as a way of answering specific clinical questions, called a “Clinical Answer”. You are invited to participate (approximately 10 minutes) by looking over a 1-page Clinical Answer, and completing a short survey afterwards.

Your participation in this study will help us develop Clinical Answers that are both useful and usable for paediatricians.

Step 1: Look over an example of a Clinical Answer (5 minutes). It may be helpful to keep the Clinical Answer document open while you are completing the survey. 
http://www.cochranechildhealth.ualberta.ca/CA_Bronchiolitis.pdf

Step 2: Complete the online survey (5 minutes). 
https://surveys.aict.ualberta.ca/tsqs/rws5.pl?FORM=Feedback_c

Your participation, and the data from the survey, are anonymous.

Thank you, we deeply appreciate your participation. Also, please help us by forwarding this invitation to your paediatrician colleagues who may be interested.

Iva Seto, BSc BA MLIS
Research Coordinator, The Cochrane Child Health Field
(www.cochranechildhealth.org)
The American Academy of Paediatrics (AAP) 2010 National Conference & Exhibition, one of the world's largest educational events in paediatrics was held in San Francisco, USA on 2-5 October 2010.

This year’s conference attracted approximately 13,000 delegates. The scientific programme covered a wide range of thematic streams and included multiple interactive, practical and networking sessions.

In addition to the top-notch CME programming offered by AAP, the flagship pre-conference event, Paediatrics for the 21st Century (Peds 21), turned its focus this year to Health Information Technology and Quality. The importance of HIT for improving patient outcomes, and the latest technology was on display in the AAP Paediatric Office of the Future to help delegates in their ascent for quality improvement.

The programme also included several special events including the Opening Plenary Sessions, the Welcome Reception, the Ribbon Cutting Ceremony in the Exhibit Hall, the President's Reception, the Annual Business Luncheon and many more.

Next year the AAP National Conference will take place in Boston, 15-18 October 2011.

The 9th Congress of Croatian Pediatric Society (CPD) was held in Požega on 6-9 October 2010. The city of Požega is located in northwest Croatia and is well-known for its outstanding Department of Pediatrics. 330 pediatricians participated in the Congress of CPD, making it the most successful congress of CPD so far. The presidents of national pediatric societies from Slovenia, Austria, Hungary and Bosnia and Herzegovina were also present: Dr. Ivan Vidmar, Professor Wilhelm Kaulfersch, Professor Laszlo Szabo and Dr. Željko Rončević. Dr. Ivan Vidmar was proclaimed the first honorary member of the Croatian Pediatric Society.

Introductory lectures were held by eminent guest lecturers. Professor Shimon Barak from Tel Aviv presented the current situation in primary pediatric care in Europe. Professor Fabrizio Simonelli from Florence expounded on the difficulties of children during their hospital stay. Professor Wilhelm Kaulfersch presented the work of European Pediatric Association and CPD’s active participation in its work. Then he introduced the 5th Europaediatrics congress that will be held in Vienna in June 2011. Professor Julije Mestrovic presented the current situation in Croatian pediatrics, especially in relation to the appearance of new diseases in children.

Representatives of Croatian Pediatric Subspecialty societies and sections lectured on guidelines and recommendations of the societies and respective sections. Their articles have been published in the
supplement of Croatian pediatric journal Paediatria Croatica. The same articles will also be published on CPS’s web page.

A large number of original articles have been submitted for the Congress. The steering committee chose 20 of them to be delivered as oral presentations, and 130 papers were presented in poster form. The best original papers were announced at the gala dinner, and the rewards were given to their first authors: docent Alenka Gagro, Dr. Marija Radonic, and Dr. Branka Polic.

The three winners whose papers were published in scientific journals in between two Congresses were announced during the ceremonial part of the Congress. The awarded papers are the ones from Professor Ivo Baric, Professor Ljerka Cvitanovic Sojat and Gordana Jakovljevic MD, PhD. The authors presented their papers and those of their associates at plenary lectures. The works of young pediatricians have been presented in the same way. The ‘Ernest Mayerhofer’ award was given to Dr. Iva Hojsak, and the ‘Radovan Markovic’ award to Dr. Tamara Zigman.

During the Congress different aspects of children’s health care were considered, and the general attitude of the Congress’ participants is consistent with the conclusions of European Pediatric Society on special responsibility of pediatricians in children’s healthcare in the modern world (The EPA / UNEPSA Committee on Challenges and Goals of Paediatrics in the 21st Century. Acta Paediatrica 2010; 99:13–18).

Acknowledgements for distinctive and lasting contribution to improving health care for children and the pediatric profession in the Republic of Croatia were given to former presidents of CPS, Professors Vlado Oberiter, Duško Mardešić, Mladen Krž and Josip Grgurić, and the longtime director of Croatian Pediatric School, Professor Livio Balarin.

At the end of the Congress two round tables were held with topics of general interest. The round table on “Primary pediatric care” was about the responsibility of a pediatrician in preservation of children’s health, especially by means of prevention methods. The difficulties in work of pediatricians in primary health care were presented as well as the perspectives of organizing primary pediatric care in Croatia. The round table on “Prevention of injuries of children” and introduction of national program of the Ministry of Health and Social Welfare included participation of representatives of the Ministry of Health and Social Welfare, the police and civil associations, along with pediatricians and family practitioners.

News from around the world

PORTUGAL

The 11th Congress of the Portuguese Paediatric Society (SPP) was held in Funchal at the island of Madeira on 6-8 October 2010. The congress focused on the following areas of paediatric care:
• Training and Research
• Community Paediatrics in the Community
• Emergency Paediatrics

These subjects were covered in 11 conferences, 14 round tables, 7 sessions of “Meet the Professor”, seven workshops and a course. 86 Portuguese and 8 international distinguished speakers run these sessions and shared their scientific knowledge with
the audience. This year’s congress attracted 700 delegates.

435 abstracts were submitted and 97% of them were accepted and presented in the context of the congress: 49 oral presentations, 102 posters with classroom presentation and discussion and 272 display posters. The evaluation was conducted by the national jury of the joint committee of the Directorate of SPP and the respective sections. Special prizes were awarded to the best abstracts.

EPA/UNEPSA was present at the exhibition area of this important meeting and promoted the future events and initiatives of the Association.

Next year the 12th Congress of the Portuguese Paediatrics Society will take place on 6-8 October 2011 in Albufeira, Algarve.

SLOVENIA

Slovenian Paediatric Society organises its national congress every four years. The 5th Congress of the Slovenian Paediatric Society took place at Radenci on 16-18 September 2010. Radenci is located in the northeast part of the country. The congress is primarily aimed at paediatricians in primary, secondary and tertiary care and attracted 250 delegates.

Paediatric Emergencies, Chronically Ill Child on Primary Level of the Health Care, Management of Resistant Epilepsy in Children and Adolescents were the main topics. Various hot topics were covered by distinguished national and European experts.

News from around the world

Prof. Andreas Konstantopoulos during his speech at the 5th Congress of the Slovenian Paediatric Society

Picture from the EPA/UNEPSA booth at the 11th Congress of SPP in Funchal, Portugal
Calendar of Events

2011

The 15th Congress of pediatricians of Russia “Actual problems of pediatrics”
RUSSIA, Moscow, 14-17 February, 2011

1st Global Congress for Consensus in Pediatrics and Child Health
FRANCE, Paris, 17 - 20 February 2011

11. Jahrestagung der Gesellschaft fur Paediatrische Sportmedizin
GERMANY, Munich, 18 - 20 February 2011

2011 Neonatal Ultrasound Course
Why, how and when an ultrasound image?
ITALY, Florence, 14-17 March 2011

11th Congress of the European Society of Magnetic Resonance in Neuropaediatrics – ESMRN
NETHERLANDS, Amsterdam, 24 - 26 March 2011

Royal College of Paediatrics and Child Health
Annual Conference 2011
UK, Warwick, 5-7 April 2011

37. Jahrestagung der Gesellschaft für Neuropädiatrie
GERMANY, Munich, 7 - 10 April 2011

33rd UMEMPS Congress & 13th Congress of Jordanian Pediatric Society
JORDAN, Amman, 4-7 May 2011

12th International Congress of Pediatric Laboratory Medicine –ICPLM

22nd International Congress of the European Society of Pediatric Intensive Care –ESPNIC
GERMANY, Hannover, 25 - 28 May 2011

29th Annual Meeting of the European Society for Paediatric Infectious Diseases –ESPID
NETHERLANDS, Hague, 7 - 11 June 2011

16th Congress of the European Union for School and University Health and Medicine (EUSUHM-2011)
RUSSIA, Moscow, 9 - 11 June 2011

49th Panhellenic Congress of Paediatrics
GREECE, Costa Navarino, Messinia, 10 - 12 June 2011

European Society for Developmental Perinatal & Paediatric Pharmacology - ESDP 2011
NORWAY, Oslo, 15 - 17 June 2011

12th European Congress of Paediatric Surgery –EUPSA
SPAIN, Barcelona, 15 - 18 June 2011

23rd Congress of the International Association of Paediatric Dentistry –IAPD
GREECE, Athens, 15 - 18 June 2011

58th Annual International Congress of the British Association of Paediatric Surgeons –BAPS
UK, Belfast, 19 - 22 June 2011

5th Europaediatrics 2011
AUSTRIA, Vienna 23 - 26 June 2011

7th European Meeting of the International Society for Neonatal Screening –ISNS
SWITZERLAND, Geneva, 28 - 30 August 2011

2nd International Signa Vitae Conference in Pediatric / Neonatal Intensive Care and Anesthesiology
CROATIA, Split, 2 September 2011

Excellence in Child Mental Health
TURKEY, Istanbul, 1 - 3 December 2011

Excellence in Paediatrics
TURKEY, Istanbul, 1 - 3 December 2011
List of Member Countries

Albania
Albanian Pediatric Society

Armenia
Armenian Association of Pediatrics

Austria
Österreichische Gesellschaft für Kinder- und Jugendheilkunde (OEGKJ)

Belgium
Société Belge de Pédiatrie/Belgische Vereinigung voor Kindergeneeskunde

Bosnia and Herzegovina
Pediatric Society of Bosnia and Herzegovina

Bulgaria
Bulgarian Pediatric Association

Croatia
Croatian Pediatric Society

Cyprus
Cypriot Pediatric Society

Czech Republic
Czech National Pediatric Society

Denmark
Dansk Paediatrisc Selskab

Estonia
Estonian Pediatric Association

Finland
Finnish Pediatric Society

France
Société Française de Pédiatrie

Georgia
Georgian Pediatric Association

Germany
Deutsche Gesellschaft für Kinder- und Jugendmedizin (DGKJ)

Greece
Hellenic Paediatric Society

Hungary
Hungarian Pediatric Association

Ireland
Royal College of Physicians of Ireland/Faculty of Paediatrics

Israel
Israeli Pediatric Association

Italy
Società Italiana di Pediatria

Latvia
Latvijas Pediatriju Asocijacija

Lithuania
Lithuanian Paediatric Society

Luxembourg
Société Luxembourgeoise de Pédiatrie

Macedonia
Pediatric Society of Macedonia

Moldova
Moldovan Paediatric Society

The Netherlands
Nederlandse Vereniging voor Kindergeneeskunde

Poland
Polskie Towarzystwo Pediatriczne

Portugal
Sociedade Portuguesa de Pediatria

Romania
Societatea Română de Pediatrie
Societatea Româna de Pediatrie Socială

Russia
The Union of Paediatricians of Russia

Serbia and Montenegro
Paediatric Association of Serbia and Montenegro

Slovakia
Slovenska Pediatricka Spolocnost

Slovenia
Slovenian Paediatric Society

Spain
Asociación Española de Pediatría

Sweden
Svenska Barnlakarforeningen

Switzerland
Société Suisse de Pédiatrie/Schweizerische Gesellschaft für Padiatrie

Turkey
Türk Pediatri Kurumu

Ukraine
Ukraine Pediatric Association

United Kingdom
Royal College of Paediatrics and Child Health

Roll over your mouse to visit the websites of the National Associations.

Visit www.epa-unepsa.org for contact information for each member organisation.
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