WOMEN'S HEALTH AND PAEDIATRICS
PAEDIATRIC DEPT

MANAGEMENT OF FEVER AND PETECHIAE

Amendments			
Date	Page(s)	Comments	Approved by
Jan 2014	New Guideline		Paediatric Guideline Group
March 2018		Whole Guideline review to align with NICE recommendations	Paediatric Guideline Group

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In Consultation with:

Ratified: Paediatric Guidelines Group

Date Ratified: Jan 2014

Date Reviewed: December 2019

Next Review Date: December 2023

Target Audience: Doctors, nurses and support staff working Paediatrics

Impact Assessment Carried Out By:

Comments on this document to: Dr Sonali D'Cruz, Dr Gillian Baksh Consultant paediatricians

Investigation and management in children and young people with petechial rash

Perform a very careful examination for signs of meningitis or septicaemia in children and young people presenting with petechial rashes

Give intravenous ceftriaxone immediately to children and young people with a petechial rash if any of the following occur at any point during the assessment (these children are at high risk of having meningococcal disease):

- petechiae start to spread
- the rash becomes purpuric
- there are signs of bacterial meningitis
- there are signs of meningococcal septicaemia
- the child or young person appears ill to a healthcare professional.

If a child or young person has an unexplained petechial rash and fever (or history of fever) carry out the following investigations:

- full blood count
- C-reactive protein (CRP)
- coagulation screen
- blood culture
- whole-blood polymerase chain reaction (PCR) for *N meningitidis*
- blood glucose
- blood gas.

In a child or young person with an unexplained petechial rash and fever (or history of fever) but none of the high-risk clinical manifestations

- Treat with intravenous ceftriaxone immediately if the CRP and/or white blood cell count (especially neutrophil count) is raised, as this indicates an increased risk of having meningococcal disease.
- Be aware that while a normal CRP and normal white blood cell count mean meningococcal disease is less likely, they do not rule it out. The CRP may be normal and the white blood cell count normal or low even in severe meningococcal disease.

- Assess clinical progress by monitoring vital signs (respiratory rate, heart rate, blood pressure, conscious level [Glasgow Coma Scale and/or APVU], temperature), capillary refill time, and oxygen saturations. Carry out observations at least hourly over the next 4–6 hours.
- If doubt remains, treat with antibiotics and admit to hospital.

If the child or young person is assessed as being at low risk of meningococcal disease and is discharged after initial observation, advise parents or carers to return to hospital if the child or young person appears ill to them.

Be aware that in children and young people who present with a non-spreading petechial rash without fever (or history of fever) who do not appear ill to a healthcare professional, meningococcal disease is unlikely, especially if the rash has been present for more than 24 hours. In such cases consider:

- other possible diagnoses
- performing a full blood count and coagulation screen.

Reference: NICE (2015) CG Meningitis (bacterial) and meningococcal septicaemia in under 16s: recognition, diagnosis and management