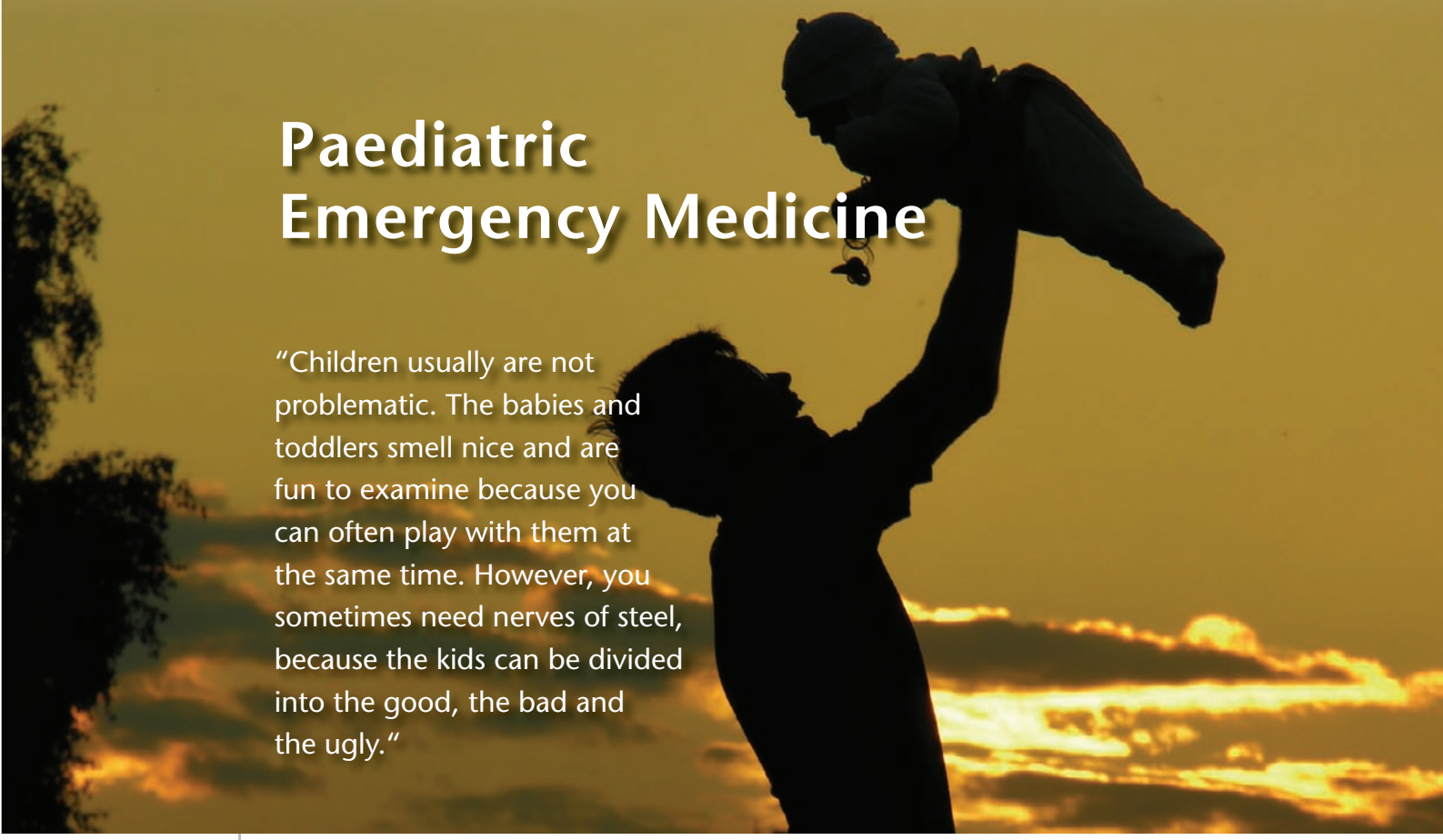
By Dr Ng Kee Chong



Paediatric Emergency Medicine

"Children usually are not problematic. The babies and toddlers smell nice and are fun to examine because you can often play with them at the same time. However, you sometimes need nerves of steel, because the kids can be divided into the good, the bad and the ugly."

THE BEGINNING

Paediatric Emergency Medicine first came into being in May 1997, when the new KKWCH opened its doors. That was when we started running a Children's Emergency (CE) Department in Singapore. Prior to this, emergency and acute paediatric care was shared by both the paediatricians as well as the emergency medicine physicians. With the establishment of Singapore's first and only children's hospital, many of the services that had previously been scattered and decentralised would now be housed under one roof. The journey leading to the eventual opening of the CE was memorable. The slate was essentially clean, the road ahead unknown. Dr Sim Tiong Peng (who served as Head from 1997 to 2005) was tasked with setting up the entire workflow and clinical needs of this brand new department.

We saw our first 'official' patient at 7.45am on Saturday, 10 May 1997. The past eight years have certainly whizzed by, and I have very fond memories of all the doctors and nurses who have passed through the department.

THE GOOD, THE BAD AND THE UGLY

Patients:

Children usually are not problematic. The babies and toddlers smell nice and are fun to examine because you can often play with them at the same time. However, you sometimes need nerves of steel, because the kids can be divided into the good, the bad and the ugly.

The good ones are babies who repeatedly smile and coo at you, and the angels who show confidence in your professional competence and allow you to examine them thoroughly. Still, babies have occasionally demonstrated their adequate hydration and urinary projectile abilities by peeing on us. In this era of SARS where we wear OT *bajus*, it is not much of a hassle since we can just change into a new set. Just be careful not to laugh too much, lest the kid aims straight for your oral cavity! Then there are other kids who have obviously been primed. When you shine a pen-torch at pre-schoolers, they almost always open their mouths wide, even though you are checking for their pupillary response!

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The bad ones are those who scream, shut their eyes and close their mouths. They will not cooperate and just pout.

The ugly ones do the above and in addition, kick, spit, scratch and scream loud enough to be heard over at the Istana. They can hit you anywhere, including some very sensitive spots below your belly button. This usually starts when you try to get a look at their throats. All hell breaks loose and seemingly angelic patients morph into screaming banshees. That is why we invariably examine throats only at the end of a consultation.

Parents and Care-givers:

Most will agree that they are the reasons why many shy away from doing paediatrics. Yes, parents and care-givers can be very demanding.

As 80% of our cases are medical complaints, it is not unusual to hear that a child 'always has phlegm.' No cough – just phlegm. Many parents will then request to have the 'phlegm' sucked out.

Some diagnoses are taboo in the CE. Telling a mother that you 'suspect' – only 'suspect', mind you – her child of having asthma is like sounding the death knell.

Other dreaded conditions include the Hand-Foot-Mouth Disease, pneumonia, and recently, dengue. That is when we need to put things in perspective and explain that these illnesses are not rare or uniformly serious in order to put their minds at ease.

To survive in the CE, you need to be well-versed in the issues of fever and its management. Common parental misconceptions are that simple head injuries cause fevers, teething causes very high fever and that fever, in the absence of any other constitutional signs and symptoms, invariably damages the brain.

Living in the CE fish bowl teaches you how to deal with concerned parents and care-givers. The crux of it is to hone your communicative skills. That is when medicine becomes not just a science but an art.

MEMORABLE CASES

A 1-year-old child came with a few months' history of unilateral nasal discharge. Under conscious sedation, we subsequently removed a green seed from the nasal cavity. It was quite bloated and looked ready to sprout if given the chance. His mother was in seventh heaven and proceeded to take multiple photos of the seed and the sedated child. When I asked why, she said that her husband had been dismissive of his son's symptoms and she wanted evidence to 'prove him wrong'.

You sometimes get irritated when you repeatedly see patients with coughs and colds. You look at the list and read about a 3-year-old with 'cough for two months' and inwardly groan. Another vasomotor rhinitis, you say to yourself. You call the kid, take a history, then auscultate and hear bilateral crepitations with decreased air entry at the right lung base. An X-ray reveals pneumonia, and you invariably feel guilty for having prejudged the case.

A 4-year-old comes in with 'fever for one day'. When you take the history from the mother, the symptoms clearly point to the common cold, and even the mother tells you as much. You find yourself being impatient and curt, saying that a well-educated person like her should first bring the child to a family physician rather than jam up the CE. Then the shoe drops. When you ask her for contact history, she breaks down and tells you that the child's sibling just died of myocarditis a month ago. He too had initially presented with exactly the same symptoms as his younger brother.

PROGRESS AND DEVELOPMENT

Almost a decade has passed, and the question has evolved from "Is there a need for paediatric emergency medicine?" to "How should paediatric emergency medicine move forward?"

Besides basic clinical work, we also helped the late Prof Chao Tzee Cheng set up the Child Safety Centre in KKH. Today, we continue to play a major role in 'Child Safety' advocacy programmes. We are also the main paediatric partner collaborating with the Drug and Poison Information Centre (DPIC) in managing paediatric toxicology cases.

The department has a comprehensive trauma service as well as a Paediatric Mass Disaster Response plan for both conventional and unconventional situations. Last but not least, we work closely with the Singapore International Foundation (SIF) to help train staff at the National Paediatric Hospital in Phnom Penh in emergency and intensive care management. The Cambodians have marvelously risen to the challenge and improved their services significantly since we started collaborating in 2003.

As part of the national medical relief efforts, we have also helped coordinate the deployment of various paediatric and Obstetrics and Gynaecology doctors, and nurses to assist in the tsunami crisis and, most recently, the Pakistani earthquake, through the Singapore Armed Forces, Red Cross and Mercy Relief, amongst others.

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THE FUTURE

As Paediatric Emergency Medicine grows into her teenage years, we will continue to reach out to both the public and the medical community to teach and train, as well as develop and improve paediatric emergency care in Singapore.

Robert Browning writes in the first stanza of *Rabbi Ben Ezra:*

"Grow old along with me!
The best is yet to be,
The last of life, for which the first was made:
Our times are in His hand
Who saith 'A whole I planned,
Youth shows but half; trust God: see all,
nor be afraid!'" ■