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2<sup>nd</sup> Annual Conference on  
**PEDIATRIC NURSING &  
HEALTHCARE**  
&  
23<sup>rd</sup> WORLD NUTRITION &  
PEDIATRICS HEALTHCARE  
CONFERENCE

June 17-18, 2019 | Dubai, UAE



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## *Amin Gohary*

*Burjeel Hospital, UAE*

### **Intestinal obstruction in pediatrics**

Vomiting in children is common and mostly related to medical condition. However there are surgical conditions associated with vomiting which needs to be acknowledge and diagnosed early. Bilious vomiting is an ominous symptom and needs to be taken seriously. Any baby who vomits bile should be considered as having an underlying intestinal obstruction until proved otherwise.

#### **Learning Objectives:**

1. Recognize the difference between vomiting due to medical and that related to surgical pathology
2. Discuss the different causes of surgical vomiting
3. Review the impact of bilious vomiting and its significance

### **Biography**

Amin Gohary completed his MB BCH in 1972 and his Diploma in General Surgery in 1975 at Cairo University, Egypt. Prof. Dr. Amin is well known in Abu Dhabi for his extensive interest and involvement in scientific activities. He is the President of the Pediatric Surgical Association of UAE. Prof. Dr. Amin is also the founder and member of the Arab Association of Pediatric Surgeons. Currently, he is an external examiner for the Royal College of Surgeons.

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## *Monika Kaushal*

*Emirates Specialty Hospital, UAE*

### **Supportive care of the sick neonate**

Neonates are the future of the society and care of the neonates in the first few days of life is extremely unique. The little ones who have some health problems right after birth need special care in special units like NICU or SCUBU. To take care of these babies especially those who need help for their breathing we need not only especial unit, but especial infrastructures, equipment's and trained medical professional's doctors and nurses. Nurses are back bone of the neonatal care. We need to focus on the supportive care which would be required by the sick neonates. Monitoring is most effective tool for efficient ventilation especially in the first few hours. A skilled nurse's feel good or bad factor on newborn's clinical picture is to be taken as the most crucial factor for deciding management strategies for the day. It will provide early evidence of potentially dangerous conditions- gas trapping and hyperinflation help to determine optimal PEEP, give immediate feedback on the effects of changes in ventilator parameters and the real-time monitoring would reduce the need for many ancillary tests such as chest X-ray, blood gas analysis, thus decreasing the cost of health care. This will allows better control of some variables. Irrespective of the technique or mode of ventilation chosen, the nursing principles are to identify the most appropriate device, technique and strategy to achieve and maintain adequate pulmonary gas exchange, minimize the risk of lung injury/recognition and prevention of VALI (Ventilator Associated Lung Injury), reduce newborn Work of Breathing (WOB) and Optimize newborn comfort for appropriate oxygenation and appropriate ventilation. Gas transport depends on ventilation, perfusion, hemoglobin and oxygen binding. Surfactant production depends on glucose, oxygen and other nutrition. Long term neurodevelopmental outcome is dependent on maintenance of normal oxygen, BP, glucose, nutrition, developmental care. Family support minimizes stress and optimizes outcomes. Monitoring will include appearance, comfort, color, heart rate, capillary refill time, respiratory rate, chest expansion/retraction, synchrony, urine output, abdomen, feeding, Central nervous system, pain, breastfeeding, social, emotional and financial. Supportive care would include positioning, physiotherapy, prevention of nosocomial infection, surveillance of flora, provision of in-utero like milieu, minimizing oxygen demand, schedule care activities at one go-club together approach softly and gently, humidification and pulmonary hygiene and suctioning, ABG monitoring, fluid and nutritional support, sedation, analgesia and paralysis, weaning, site and type of IV access, documentation, follow up care, emotional support and good communications.

### **Biography**

Monika Kaushal has completed her MBBS, MD Pediatrics, DM Neonatology from FRCPC. She has several publications in journals which are indexed both nationally and internationally indexed journals. She has a great passion for research, teaching and dissemination of knowledge. She is currently pursuing MSc in Neonatology from Southampton University, UK.

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## **Mazen Abou Chaaban**

*Emirates Speciality Hospital, UAE*

### **Management of hypertension in children and adolescents**

**B**lood pressure in pediatric age group varies with age, sex and height. It is categorized into primary and secondary hypertension (an underlying cause can be identified). Essential hypertension is being increasingly recognized in children especially in adolescents and form 12% to 18% of the etiology of hypertension in this age group. Treatment for essential hypertension is mainly non-pharmacological in the form of weight reduction, reduction of salt intake and exercise. Mild pharmacological treatment is needed in some patients as supplementary to the other. Hypertension in children and adolescents is mainly secondary in origin. Renal parenchymal disease is the most frequent (70-80%) causes of secondary hypertension while renovascular, cardiovascular and endocrinal disorders constitute only 20-30%. In secondary hypertension, treatment of the underlying etiology is in most of the cases, the key of success in the management of hypertension. Although the approach to the treatment of hypertensive children differs somewhat from that of the adult and the general principals are similar. Pharmacological treatment is mandatory in these patients and should be done under the following rules; should be used in stepwise fashion, the least toxic drug should be prescribed first, use maximum recommended dose of one pharmacological drug prior to adding another and when combined drug therapy is used, the drug being prescribed should have different sites or modes of action in order to attain an additional effect. Some of the antihypertensive drugs used are diuretics which are used as first line of treatment as well as in combination with other medications (e.g. Thiazine, Furosemide, etc.). Beta blockers can be used safely alone or in combination with others if there is no contraindication to their use as in bronchial asthma and congestive heart failure (e.g. Propranolol, Atenolol, Metoprolol, Pindol, etc.) Their mode of action is mainly by reduction in the heart rate and cardiac output and blockage of the release of renin from the kidneys in response to adrenergic stimulation. Alpha and beta-blocking agents (e.g. Labetalol) have added useful and safe lines in the treatment of chronic as well as acute hypertensive emergencies in pediatrics. Calcium channel blocking agents act on the smooth muscle cells of the blood vessels and inhibit the influx of calcium causing inhibition of the tone of the smooth muscles leading to peripheral vasodilatation and thus reducing the peripheral resistance (e.g. Verapamil, Nefidipine, Amlodipine and others.). Angiotensin converting enzyme inhibitors block the biotransformation of angiotensin I to angiotensin II and subsequently prevent the vasoconstriction and the release of renin and aldosterone. They are of great benefit in the treatment of high-renin hypertension. Other categories of antihypertensive drugs which are used in emergencies and in non-responder children and adolescents are alpha-adrenergic blocking agents, peripheral vasodilators and centrally acting alpha stimulators. Close monitoring, follow ups, parents and patients understanding and compliance are essential to assure proper and successful management of hypertension in children and adolescents.

### **Biography**

Mazen Abou Chaaban is a Consultant Pediatrician and Pediatric Nephrologist at the Emirates Specialty Hospital in Dubai. He has received his higher education qualifications and skilled training in the field of Pediatrics and Pediatric Nephrology (kidney diseases) in Cologne, Germany and has more than 25 years of experience in Dubai. He is one of the few Doctors in the Middle East region to have vast experience in pediatric nephrology. He was also awarded a Fachartz (the highest specialty in pediatrics in Europe) and was recruited to the government hospital in Dubai to establish its first pediatric nephrology unit.

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