tial association with vaping, and start a national register of potential cases.

In light of all of the above, I consider that working groups should be created in the *Asociación Española de Pediatría* to detect and study potential side effects of vaping, and urgent strategies developed to prevent e-cigarette use in our patients.

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Primary immune thrombocytopenia: A review of cases in a district hospital☆

Trombocitopenia inmune primaria: revisión de casuística en un hospital comarcal

To the Editor:

Primary immune thrombocytopenia (ITP) is the most frequent acute form of thrombocytopenia found in previously healthy children. It is an acquired disease that manifests with a transient or persistent drop in the platelet count (<100 000). Several factors have been found to be associated with primary ITP, such as recent viral infection or administration of certain vaccines. It also exhibits a seasonal pattern with a higher incidence in winter and spring.[1]

The severity of the disease is determined based on the haemorrhagic manifestations, which do not always correlate to the platelet count. The severity can be categorised applying the criteria used in the United Kingdom[2] (asymptomatic, mild symptoms, moderate symptoms or severe symptoms).

There are several treatment options that depend on the chronicity and severity of the ITP. According to the working group on ITP of the Sociedad Española de Hematología y Oncología Pediátricas (Spanish Society of Paediatric Haematology and Oncology, SEHOP),[3] the treatment options for newly diagnosed ITP, depending on the severity and risk factors, are: observation, steroid therapy (oral prednisone or intravenous [IV] methylprednisolone) and intravenous immunoglobulin (IVIG). Chronic ITP can be treated with thrombopoietin receptor agonists, such as eltrombopag (via the oral route).

In 2017, the Department of Health detected an increase in the prevalence of ITP in our region, with a tendency to relapse in certain patients. Since there is no specific register of Spanish children with ITP, we thought it would be relevant to review the epidemiological and clinical characteristics of our patients. To that end, we carried out a retrospective descriptive study by selecting cases with diagnostic codes 287 and D69 of the International Classification of Diseases, Ninth Revision (ICD-9) in the Corporate Analysis Platform of the Department of Health of Valencia (ALUMBRA). We then collected data on the variables under study from the health records of the selected patients, entering and encoding the data in an anonymised database.

We included children aged 0 to 15 years with a diagnosis of idiopathic thrombocytopenic purpura or primary immune thrombocytopaenia managed in our department between 2002 and 2017. We excluded patients with a neonatal diagnosis.

The independent variables were: infection or vaccination in the month preceding diagnosis, age at diagnosis, month of onset and sex.

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Table 1 Epidemiological data and ordered diagnostic tests.

Age at diagnosis	
Mean	4 years and 4 months
Median (range)	35 months (7 months–12 years and 4 months)
Time elapsed from onset to diagnosis	
Mean	15 days
Median (range)	6 days (0–180 days)
Severity	
Mild	87%
Moderate	8%
Severe	5%
Length of stay	
Median (range)	3 días (0–12 días)
Diagnosis by semester	
January–June	26
July–December	13
Vaccination in the previous month	6
Meningococcal C + pentavalent (DTP, Hib, HBV)	2
MMR + pneumococcal	1
MMR	2
MMR + DTP	1
Infection in the previous month	19
Viral	17
Respiratory tract	13
Gastroenteritis	3
Varicella	1
Bacterial	2
Acute otitis media	1
Acute tonsillitis	1
Platelet count	
Median (range)	8000 (1000–58 000)
Serology (positive/total orders)	6/20
EBV IgM	3
VH6 IgM	1
Varicella IgM	1
Echovirus IgM	1
Bone marrow aspirate	
Performed in	10 patients
After (mean; range)	15 months (1–180)

The dependent variables were: incidence, prevalence, platelet count at diagnosis, time elapsed from onset to diagnosis, length of stay, severity,[2] number of relapses during follow-up through 2018, and treatment (observation, steroid therapy, gamma globulin, eltrombopag).

The study was approved to be conducted in our hospital by the competent ethics committee and by the Research Committee of the Department of Health.

We performed a descriptive analysis with the statistical software SPSS. We have described variables as mean and standard deviation (SD) if normally distributed, and otherwise as median and range. We assessed the normality of the distribution with the Kolmogorov–Smirnov test.

We found an incidence of 9.23 cases per 100 000 paediatric-aged inhabitants and a prevalence of 24.87 cases per 100 000 paediatric-aged inhabitants in 2017. We found that 39 patients had received a diagnosis of ITP (51% female and 49% male). Table 1 summarises the epidemiological characteristics of the identified cases and the diagnostic tests ordered in the evaluation, along with their results.

Observation was the initial approach in 4, although ITP resolved spontaneously only in 2. Seventy-four percent of patients received IVIG and 56% corticosteroids (overall, 41% of patients required both treatments). Patients treated with IVIG received a median of 2 doses (range, 1–15). Due to progression to chronic ITP, 2 patients were treated with eltrombopag.

Of the 39 patients, 7 progressed to chronic ITP and 2 to persistent ITP, while 1 died as a result of intracranial bleeding, with contradictory findings of the post-mortem examination of the bone marrow and the skullcap as to whether the site of origin was deep or superficial.

Salient findings of our study include a shorter length of stay in the group with moderate symptoms compared to the group with mild symptoms, a result that could be biased due to transfer to a tertiary care hospital. Also, our data corroborated the increase in cases in the winter and spring, and the association with vaccination or infection in the month preceding onset.

As regards the treatment and outcomes of ITP, there are several limitations to our study. On one hand, due to the retrospective design, in the early cases the occurrence of relapses, the response to treatment and the indication for treatment were established based on the judgment of the physician in charge, whereas in later years they were established based in international guidelines.[4] Furthermore, the sample was small, so it is difficult to draw conclusions on the subject.

The approach to the treatment of patients with ITP varies between hospitals, so there is a need to standardise its management.

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Screening for abuse in emergency departments: A pending issue☆,☆☆

Cribado de maltrato en urgencias, una asignatura pendiente

Dear Editor:

The detection of child abuse is essential to allow adequate intervention with the aim of improving the situation of the patient and prevent its recurrence. Emergency departments (EDs) are the main point of entry to the health care system for many patients, yet several studies have demonstrated that detection of abuse could improve in the emergency care setting.[1] The challenge posed by the differential diagnosis of many injuries, in which abuse may be confused with accidental, infectious or neurologic aetiologies, combined with the heavy workloads in EDs, results in failure to detect abuse in some instances, which may have significant consequences for the child. Due to these difficulties, different screening methods have been developed that are used routinely in in some countries,[1,2] but not in Spain, where their application has not been studied. In this context, the Working Group on Abuse of the Sociedad Española de Urgencias Pediátricas (Spanish Society of Paediatric Emergency Medicine, SEUP) carried out a multicentre study to assess the tools used to screen for abuse in paediatric EDs in Spain.

We designed an observational descriptive study with data collection by means of questionnaires. The study was approved by the clinical research ethics committee of the hospital. In November 2018, we contacted the directors of the EDs affiliated with the SEUP to request their participation in the study. We provided the link to an online questionnaire and sent 2 reminders by email in the 2 months that followed. The questionnaire included items about the characteristics of the ED, the methods used for detection of abuse, the existence and type of child abuse protocol and its availability. We contacted 80 directors and received responses from 39 of them (48.8%), corresponding to hospitals in 16 autonomous communities of Spain. Table 1 presents the characteristics of participating hospitals. In every hospital, abuse was suspected based on the findings of the history and the physical examination. None of the hospitals used a standardised abuse screening tool, and 5 (12.8%) were planning introducing one in the near future. Thirty-seven hospitals (94.9%) had a child abuse protocol in place in the emergency care setting (29 an in-house protocol and 8 a regional protocol) and 33 (84.6%) reported that the staff was acquainted with the protocol.

Based on our findings, we surmise that the suspicion of abuse in EDs depends exclusively on the ability of physicians to identify it, which in turn depends greatly on their training and experience on the subject. It is also worth noting that a large proportion of hospitals still did not fulfil the child abuse quality indicator established by the SEUP,[3] which involves the existence of a child abuse protocol accessible to the ED staff, who in turn should be aware of its location. The lack of standardization involves a considerable heterogeneity in the approach to the identification of abuse, so that existing cases may go undetected, even severe ones.[4] If we increase the frequency of early detection, the outcomes of these children may improve.[4,5] A recent study found that the use of a screening checklist such as the SPUTOVAMO combined with a top-to-toe physical examination of all patients that visited the ED was a good method for detection of possible cases of abuse.[6] On the other hand, Rumball-Smith et al. have advocated for the integration of a child abuse screening tool in the electronic health record system to be completed for every patient, as the authors observed an increase in the number of reported cases of suspected abuse.[2] However, depending on the level of care and workload of each hospital, these strategies may be difficult to implement in Spain. One option, perhaps as a first step to improve detection, is to programme red flag alerts in the electronic health record system to be triggered with certain discharge diagnoses to alert the physician in charge of the potential of abuse before the patient is discharged. This would give the physician the opportunity to complete the child abuse checklist and review all the records shared in the system before discharging the patient, or to start an evaluation to address this suspicion. A similar option is being investigated for implementation in primary care clinics in Catalonia, and we believe that its implementation in EDs would be feasible. For this or other strategies, it is essential that patient records are available electronically and that the information contained in the electronic health records can be shared by the health care staff of different facilities while safeguarding confidentiality.

In conclusion, given the deficiencies observed in the EDs under study, it is our duty as specialist in paediatric emergency care to promote the knowledge and implantation of screening tools and to disseminate existing screening protocols to attempt to improve the care of potential victims of abuse and reduce its potential impact.

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