Limping Child Pathway

NHS

Clinical Assessment/Management tool for Children

Primary and Community Care Settings

History	Examination	Red Flags	
• Duration and progression of limp • Characteristics of the pain • Presence of systemic features • Recent illness, travel, medication or trauma • Birth and development history • Family history of rheumatological or neuromuscular disease	• Check temperature • Pallor, irritability, lethargy, lymphadenopathy, rash, bruising • Examine whole leg, including hip, spine and abdomen (including testes) • Use pGALS • Refer to causes of limp table (see page 2)	• Completely non-weight bearing • Severe pain • Pseudo-paralysis of limb • Night pain • Fever • Immunocompromised child • Localized bone pain • Pallor/bruising	• Organomegaly • Night sweats • Weight loss • Back pain, in an unwell child • Delayed presentation • Inconsistent history • Unusual pattern of injury or multiple injuries

GREEN LOW RISK	AMBER MEDIUM RISK	Infection Red Flags	Malignancy Red Flags	Other
• Symptoms less than 72 hours or >72 hours and improving • No history of trauma • No safeguarding concerns • Able to weight bear but limping • Well • No red flags	• Symptoms more than 72 hours and no improvement • Representation with similar symptoms • Unable to weight bear • No red flags	• Temperature >38°C • Rigors • Red, swollen joint • Non-weight bearing • Pain on moving joint (passive)	• Fatigue, anorexia, weight loss, night sweats • Pain waking child at night • Pallor, lymphadenopathy, organomegaly	• History of trauma or focal bony tenderness • Safeguarding concerns

GREEN ACTION	AMBER ACTION	RED ACTION Urgent Acton	RED ACTION Urgent Acton	RED ACTION other

• Likely Transient Synovitis
• Regular analgesia with ibuprofen and paracetamol
• Advise to take to A&E if symptoms worsen, fever or systemically unwell
• Review in 48 - 72 hours
• Concerns about slipped upper femoral epiphysis or safeguarding concerns low threshold for same day x-ray
• If not improving at 48-72 hours, not resolved by 1 week or any uncertainty about diagnosis, move to amber actions
	• Arrange Speciality assessment, urgency depending on clinical judgement, if:
	  • Uncertainty about cause of limp
	  • Cause cannot be managed in primary care (refer to appropriate specialist, for example Orthopaedics, Paediatrics, A&E)
	  • Presentation with limp on multiple occasions
	NICE CKS Child with limp
		• Send child to Paediatric Emergency Department or Paediatric Assessment Unit	• Phone Paediatrician-On-Call to arrange urgent same day assessment	• If safeguarding concerns referrer must contact Social Care as per local guidance prior to referral to secondary care
				• If history of trauma refer to ED as per local policy

This guidance has been reviewed and adapted by healthcare professionals across West Yorkshire with consent from the Hampshire development groups

Causes of Limp

<table>
<tr><th>Age Less than 3 Years</th><th>Age 3 – 10 years</th><th>Older than 10 years</th><th>Any Age</th></tr>
<tr>
<td>Septic Arthritis (SA)/Osteomyelitis (OM)
Usually febrile
Most commonly occurs under 4 years of age
Pain and inability to weight bear
Child often looks unwell
Passive movement of joint is extremely painful
SA of Hip, hip often held flexed and abducted
Femoral OM - children may have some passive range of movement if no extension into joint
Requires urgent assessment and treatment
Septic Arthritis is a medical emergency
Developmental Dysplasia of hip
Painless limp since onset of walking or delayed walking
Transient synovitis is less common below 3 years of age.

Fracture/soft tissue injury

Toddlers fracture
Subtle undisplaced spiral fracture of tibia caused by sudden twist, often unwitnessed fall
Non-Accidental Injury</td>
<td>Transient synovitis
Typically acute onset following a viral infection
No systemic upset
Peak onset age 5/6 years, more common in boys
No pain at rest and passive movements are only painful at the extreme range of movement
Recurs in up to 15% of children
Managed with oral analgesia
Septic arthritis (SA)/ osteomyelitis (OM)

Fracture/soft tissue injury

Perthes disease
Usually occurs in children aged 4-10 years (peak 5 to 7 years)
Affects boys more than girls
Bilateral in 10%
Consider if persisting limp
Insidious onset painless limp
Can progress to avascular necrosis of femoral head</td>
<td>Septic arthritis (SA) / osteomyelitis (OM)

Slipped upper femoral epiphysis (SUFE)
Usually occurs aged 11-14 years
More common in obese children and in boys
Bilateral in 20-40%
Sudden onset hip or knee pain
Restriction of internal rotation
Same day Xray essential – delayed treatment associated with poor outcome
Perthes disease

Fracture/soft tissue injury

Mechanical including overuse

Injuries & stress fractures

Osgood-Schlatter's disease

Sever's disease</td>
<td>Septic arthritis (SA) / osteomyelitis (OM)

Malignancy including leukaemia, neuroblastoma, bone tumour
Weight loss or poor appetite
Easy bruising
Pallor
Abdominal mass
Miserable
Bone pain and swelling
Non-malignant haematological disease e.g. haemophilia, sickle cell

Metabolic disease e.g. rickets, Vitamin D deficiency

Neuromuscular disease e.g. cerebral palsy, spina bifida

Limb abnormality e.g. length discrepancy

Inflammatory joint or muscle disease e.g. JIA
Consider where limp persistent for 6 weeks or more
Affects the hip in 30-50% and usually bilateral
Uncommon for hip monoarthritic as initial presentation
Typically present with groin pain, may have referred thigh or knee pain
Often history of morning stiffness with gradual resolution of pain with activity
There is painful or decreased range of motion especially in internal rotation
Analgesia should be started and referral to paediatrics/paediatric rheumatology
Appendicitis / Testicular torsion / UTI</td>
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