### Lymphadenopathy Pathway

**Clinical Assessment/Management tool for Children with Lymphadenopathy**

#### Management - Acute Setting

**Lymphadenopathy (LAN) in Children**

<table>
<thead>
<tr>
<th>Green – Low risk</th>
<th>Amber – Intermediate risk</th>
<th>Red – High risk</th>
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<tbody>
<tr>
<td><strong>Size</strong></td>
<td>Less than 2cm</td>
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</tr>
<tr>
<td><strong>Site</strong></td>
<td>Cervical, axillary, inguinal</td>
<td>Supraclavicular or popliteal nodes especially concerning</td>
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<tr>
<td><strong>History</strong></td>
<td>Recent viral infection or immunisation</td>
<td>Fever, weight loss, night sweats, unusual pain, pruritis</td>
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<td>Eczema, Viral URTI</td>
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**Lymphadenitis / lymph node abscess** – painful, tender unilateral LN swelling. Overlying skin may be red/hot. May be systemically unwell with fever.

- **EBV** – cervical or generalised LAN, exudative pharyngitis, fatigue, headache +/- hepatosplenomegaly.

**Atypical mycobacterial infection** – non-tender, unilateral LN enlargement, systemically well. Most common between 1-5 years of age. Progresses to include overlying skin discolouration. Consider mycobacterium tuberculosis – any risk factors?

**Cat-scratch disease** – usually axillary nodes following scratch to hands in previous 2 weeks. Highest risk with kittens.

### Reactive LAN
- Reassure parents that this is normal - improves over 2-4 weeks but small LNs may persist for years
- No tests required
- Provide advice leaflet

### LAN due to poorly controlled eczema
- Generalised LAN extremely common
- Optimise eczema treatment.
- If persists, check full blood count and blood film and/or refer to general paediatric outpatient - patients
- Provide advice leaflet

### Actions
- If lymphadenitis, treat with 7 days of co-amoxiclav.
- Review progress after 48 hours. If remains febrile, may need drainage
- If systemically unwell or suspected LN abscess, phone paediatrician-on-call.
- If suspected atypical mycobacterial infection associated with disfigurement, refer to ENT clinic.
- Consider blood tests as appropriate such as full blood count, blood film, EBV serology
- Consider TB testing
- Provide advice leaflet

**Differential includes malignancy (leukaemia / lymphoma) and rheumatological conditions (JIA / SLE / Kawasaki disease)**

- Urgent referral to paediatric team
- Consider FBC, U+E, LDH, EBV serology, CRP and blood culture.

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*Also think about ... TB*

Is there a history of TB exposure, travel to a high risk area - discuss concern with local infectious disease specialist.

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This guidance was written in collaboration with the SE Coast SCN and involved extensive consultation with healthcare professionals in Wessex.

This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and/or carer.

GMC Best Practice recommends: Record your findings (See “Good Medical Practice” [bit.ly/1DPXl2b])

**Table 1**

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