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Topics on radiation exposure

- Treatment of radiation injury in the adult
- Biology and clinical features of radiation injury in adults
- Management of radiation exposure in children following a nuclear disaster
- Clinical features of radiation exposure in children

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- **Treatment of hypertension in children and adolescents**
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- Symptomatic management of nephrotic syndrome in children
- Overview of the management of chronic kidney disease in children
- Management of coarctation of the aorta
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- Management of patent ductus arteriosus
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Topic Outline

INTRODUCTION

DEFINITIONS

RATIONALE FOR INTERVENTION

NONPHARMACOLOGIC THERAPY

- Weight reduction
- Exercise
 - Sports participation
- Diet
 - Salt restriction
- Potassium intake and the DASH diet
 - Avoidance of excess alcohol
 - Other CVD risk factors

PHARMACOLOGIC THERAPY

- Whom to treat
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 - Beta-blockers
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 - Angiotensin receptor blockers
 - Vasodilators
 - Combination therapy

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- BP change and salt intake

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PHARMACOLOGIC THERAPY

- Whom to treat
- Antihypertensive drugs
 - Thiazide diuretics
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 - Calcium channel blockers

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- BP change and salt intake
- Thiazide dose and fall in BP

Avoidance of excess alcohol — Multiple studies in adults have shown that excess alcohol intake and the development of hypertension. Adults who have a 1.5- to twofold increase in the incidence of hypertension compared with those who do not drink. Excess alcohol intake is most prominent when intake exceeds five drinks per day. Findings to children has not been well studied. Nevertheless, excess alcohol intake may improve weight loss, BP control, and other health concerns. (See "[Cardiovascular risk factors](#)".)

Other CVD risk factors — Smoking should be avoided by hypertensive children and adolescents because it increases the risk of CVD as well as lung cancer. In addition, smoking by family members should be avoided to prevent second-hand smoke exposure, which has been associated with premature atherosclerosis in exposed children. (See "[Smoking and hypertension](#)" and "[Secondhand smoke exposure in children](#)", section on 'Coronary heart disease'.)

Dietary measures should be initiated in children with dyslipidemia, which is defined as "Management of the child at-risk for atherosclerosis", section on 'Dyslipidemia'.

PHARMACOLOGIC THERAPY — Although antihypertensive drug therapy can lower blood pressure, it produces side effects and has not been proven to improve long-term cardiovascular outcomes. There is supporting evidence that lowering elevated childhood BP reduces the risk of premature CVD. These data include findings that demonstrate hypertensive children are at risk for accelerated atherosclerosis and are likely to remain hypertensive as adults, who are at risk for CVD. (See "[Rationale for intervention](#)" above and "[Identifying the child at-risk for atherosclerosis](#)".)

As a result, drug therapy for HTN in children should be limited to those who are most likely to benefit and a regimen should be chosen to minimize the incidence of side effects and provide the best possible compliance.

Whom to treat — In our practice, we utilize the 2004 NHBPEP guidelines to initiate pharmacologic therapy in children with one or more of the following conditions [1]:

- Symptomatic HTN (eg, headache, seizures, changes in mental status, focal neurologic complaints, visual disturbances, and cardiovascular complaints indicative of heart failure, such as chest pain, palpitations, cough, or shortness of breath).
- Stage 2 HTN defined as BP levels that are 5 mmHg greater than the 99th percentile.
- Stage 1 HTN (without any evidence of target-organ damage) that persists despite a trial of four to six weeks of treatment.

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Avoidance of excess alcohol

Multiple studies in adults have shown that excess alcohol intake and the development of hypertension. Adults who have a 1.5- to twofold increase in the incidence of hypertension compared with those who do not. Excess alcohol intake is dose-related and is most prominent when intake exceeds five drinks per week. Findings to children has not been well studied. Nevertheless, excess alcohol intake may improve weight loss, BP control, and other health concerns. (See "Cardiovascular risk factors in children", section on 'Moderate alcohol consumption'.)

Other CVD risk factors

Smoking should be avoided by hypertensive children and adolescents because it increases the risk of CVD as well as lung cancer. In addition, smoking by family members should be avoided to prevent second-hand smoke exposure, which has been associated with premature atherosclerosis in exposed children. (See "Smoking and hypertension" and "Secondhand smoke exposure in children", section on 'Coronary heart disease'.)

Dietary measures should be initiated in children with dyslipidemia, which is defined as abnormal lipid levels. (See "Management of the child at-risk for atherosclerosis", section on 'Dyslipidemia'.)

PHARMACOLOGIC THERAPY

Although antihypertensive drug therapy for children with hypertension (HTN) can produce side effects and has not been proven to improve long-term cardiovascular outcome, there is indirect supporting evidence that lowering elevated childhood BP reduces the risk of premature CVD. These data include findings that demonstrate hypertensive children are at risk for accelerated atherosclerosis and are likely to remain hypertensive as adults, who are at risk for CVD. (See "Rationale for intervention" above and "Identifying the child at-risk for atherosclerosis".)

As a result, drug therapy for HTN in children should be limited to those who are most likely to benefit and a regimen should be chosen to minimize the incidence of side effects and maximize compliance.

Whom to treat

In our practice, we utilize the 2004 NHBPEP guideline for the treatment of HTN in children with one or more of the following conditions [1]:

- Symptomatic HTN (eg, headache, seizures, changes in mental status, visual disturbances, and cardiovascular complaints indicative of target organ damage such as palpitations, cough, or shortness of breath).
- Stage 2 HTN defined as BP levels that are 5 mmHg greater than the 99th percentile.
- Stage 1 HTN (without any evidence of target-organ damage) that persists despite a trial of four to six weeks of nonpharmacologic therapy.

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Treatment of radiation injury in the adult

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 - Irradiation of blood products

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different exposures, as described below:

Accidental — Accidental exposure involves the release of radioactivity from small, usually sealed, sources (ie, nuclear medicine, brachytherapy, industrial gauges, small calibration sources), accidental overtreatment

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Treatment of radiation injury in the adult

TOPIC OUTLINE

INTRODUCTION

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 - Radiologic dispersion devices
 - Improvised nuclear devices
- Generation of radionuclides

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MANAGEMENT OF HEMATOLOGIC INJURY

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- BLOOD PRODUCTS
- Irradiation of blood products

Treatment of radiation injury

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INTRODUCTION — The occurrence of industrial and medical radiation accidents and the threat of terrorist events involving radioactive material mandate the development and implementation of an appropriate medical response. Medical professionals who would logically be involved in such events include, among others, radiation safety officers, radiologists, radiation oncologists, nuclear medicine physicians, emergency department physicians, hematologists, medical oncologists, gastroenterologists, infectious disease specialists, as well as primary care providers. All will be asked to play a significant role in evaluating and treating victims of an accidental or deliberate exposure to radiation. Due to their experience in managing patients with cytopenias and/or marrow aplasia, hematologists will most likely be asked to take primary or consultative responsibility for medically treating individuals exposed to a significant dose of radiation.

However, all physicians, and especially medical triage personnel, must have a basic understanding of how radiation alters the function of cells, tissues, and organ systems, how radiation exposure can be recognized and how victims receiving a significant radiation dose can be recognized and managed. This topic is discussed separately. (See "[Biology and clinical features of radiation injury](#)".)

Response to terrorist events resulting from a nuclear or radiological event. The International Atomic Energy Agency (IAEA) Nuclear Emergency Response Team (NERT) Working Group has developed a framework for the management of radiation exposure, clinical assessment of exposed individuals, and medical management of radiation injury [1]. Responding medical personnel must have access to the resources that may be employed in the case of a radiation emergency, as well as the treatment of patients with radiation injury.

Management of radiation exposure in children is covered separately. (See "[Management of radiation exposure in children](#)".)

ITS — Excessive radiation doses may result from a number of

Accidental — Accidental exposure involves the release of radioactivity from small, usually sealed, sources (ie, nuclear medicine, brachytherapy, industrial gauges, small calibration sources), accidental overexposure, or


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Internal contamination

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Anemia of chronic disease (anemia of chronic inflammation)

Approach to the immunocompromised patient with fever and pulmonary infiltrates

Biology and clinical features of radiation injury in adults

Clinical and laboratory aspects of platelet transfusion therapy

Clinical features of radiation exposure in children

Collection and storage of umbilical cord blood for hematopoietic cell

Initial laboratory testing — If internal contamination is suspected, collection and monitoring of secretions and excreta can be helpful. For example, obtaining bilateral nasal swab samples within the first hour of the incident can provide valuable information. As an example, the extent of nares contamination is approximately 5 percent of that received by the pulmonary alveoli. For victims in whom internal contamination is suspected, peripheral blood (for the same tests as ordered for an external exposure), urine, nasal smears, spontaneous vomitus, and stools should be obtained for radiological monitoring. Hospital staff must take precautions with the handling of these samples as they may be radioactive. Any patient with wound contamination or imbedded with radioactive fragments should be evaluated for such internal contamination.

Initial laboratory testing should include a complete blood count (CBC) with white blood cell differential and platelet count, along with routine chemistry tests. The time of CBC collection must be carefully noted, because of important time-related changes in the lymphocyte count ([table 3](#)).

If possible, serial CBCs should then be obtained every 6 to 12 hours for at least three samples. Twenty-four hours after any significant exposure, a blood sample should be drawn into a [lithium](#) heparin tube and sent to an appropriate referral lab for confirmatory chromosomal aberration analysis. This information may also aid in the patient's treatment and the determination of overall prognosis ([table 3](#)).

Additional monitoring should be based on the whole-body dose, as the onset of neutropenia and its severity are dose dependent ([figure 1](#)). Patients with low exposures may need a weekly or twice-weekly CBC for 4 to 6 weeks to document their WBC nadir and subsequent recovery.

For patients felt to have internal contamination, a 24-hour urine and stool sample every day for four days should be collected and analyzed for radionuclide contamination. Treatment guidance should be based on expert assistance, such as that obtained from the NCRP Report 65, Management of Persons Accidentally Contaminated with Radionuclides. Advice is also available on the following website: www.orau.gov/reacts.

High risk populations

Pregnancy — The dose to the gravid uterus is approximately 65 to 70 percent of that received on the surface, affording some protection to the fetus from external radiation. However, when internal radiation contamination is present, the fetus may receive a high dose due to its proximity to the maternal bladder. In addition, the fetal thyroid begins to take up iodine after 12 weeks, adding to the potential for injury (see ["Thyroid protection"](#) below and ["Management of radiation exposure in children following a nuclear disaster"](#)).

Because the fetus is very susceptible to the effects of ionizing radiation, any pregnant female exposed to radiation should also see a health physicist and a maternal fetal medicine specialist.

Children — Several unique features encountered in children enhance their vulnerability to the effects of

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Radiation biodosimetry

Dose (Gy)	Vomiting (%)	Time to vomiting (hours)	ALC day 1 (/microL)	Lymphocyte fall rate constant (k)*	Lymphocyte dicentrics (per 1000)
0	0	-	2450	-	1-2
1	19	-	2160	0.126	88
2	35	4.6	1900	0.252	234
3	54	2.6	1680	0.378	439
4	72	1.7	1480	0.504	703
5	86	1.3	1310	0.63	1000
6	94	1.0	1150	0.756	
7	98	0.8	1010	0.881	
8	99	0.7	890	1.01	
9	100	0.6	790	1.13	
10	100	0.5	700	1.26	

Gy: absorbed whole body dose in Grey units; ALC: absolute lymphocyte count per microL.

* The lymphocyte fall rate constant is derived from a semilogarithmic plot of the absolute lymphocyte count (ALC) versus time in days, in the form of $2450 \times e(-kt)$. The time (in days) for the ALC to fall to one-half of its original value [half-time, $T(1/2)$] can be obtained from the following equation: $T(1/2) = 0.693/k$.

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- Laboratory evaluation of the immune system
- Leukoreduction to prevent complications of blood transfusion
- Management of radiation exposure in children following a nuclear disaster
- Overview of infections following hematopoietic cell transplantation

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