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Review of awareness and management in the event of suspected shunt blockage

V Klimach* and S Dasgupta

Address: Department of Community Child Health, Hesketh Road, Colwyn Bay, Conwy, Wales, UK

Email: V Klimach* - Val.Klimach@cd-tr.wales.nhs.uk

* Corresponding author

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Background

Neurosurgical Services for children in North Wales are provided at some distance by Paediatric Neurosurgeons at the Tertiary Centre in Liverpool, England. In the event of urgent life threatening cases, such as shunt blockage, it is essential that good liaison exists between parents, schools, the local District General Hospital, Community Paediatricians and the Tertiary Centre.

Aims

To identify gaps in awareness and knowledge relating to CSF shunt malfunction in children with CSF shunts, amongst their families, school staff, Community and Hospital Paediatricians, GPs and Health Advisers serving the children. To ensure that any gaps in knowledge and awareness of shunt malfunction are 'plugged' by means of local guidelines. Also, specific guidance should be available at a community, primary care and secondary level to ensure rapid and appropriate referral to the Tertiary Neurosurgical Service.

Materials and Methods

15 children were identified with the ICD10 coding on the NCHS. A postal questionnaire was sent out to involved GPs, SENCOs, Community Paediatricians, school nurses, and senior and junior Paediatricians at the local District General Hospital. The questionnaires were completed personally with the families of children with shunts.

Personal communication was made with: the Tertiary Centre about written protocols for management of shunt blockage, and of written information given to parents; and with ASBAH about local service provided by them, and their available literature.

Results

Families seem well informed and confident of their own ability to recognise and act on symptoms of shunt malfunction, but were less confident about various professionals' ability to do so. Professionals (see list in "Aims") responses varied from not being able to recognise symptoms and act on symptoms of shunt malfunction, to being thoroughly competent to do so. Most said they would value written information and local guidance notes.

Recommendations

Improve communication and liaison after a CSF shunt insertion or shunt revision, and increase awareness of shunt malfunction and the action required through a communication/liaison pathway. Clarify local community/ward guidance by a proposed pathway in suspected CSF shunt malfunction. Provide clear local guidance on symptoms of shunt malfunction and suggested action for schools, ward Paediatricians, GPs and other medical/nursing professionals.