Paediatric Matters

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Re-presentations: Detecting Change, Rethinking the Differential

Patient Story*

Seven-year-old Bailey presented to the Emergency Department at 9 pm with vomiting and abdominal pain. He was reviewed by a junior doctor. His observations were temp 37.7ºC, HR 123/min, BP 102/65, RR 20/min, O^2 sats 99% (CEWT 0). His abdomen was soft and non-tender. A preliminary diagnosis of gastroenteritis was made, and an oral fluid trial commenced. After a period of observation, Bailey was discharged home with a gastroenteritis fact sheet.

The next day, Bailey re-presented with persistent symptoms. His parents were concerned he wasn't improving. He was reviewed by a different junior doctor, who noted the previous gastroenteritis diagnosis and admitted him for observation. His vital signs were temp 38.3ºC, HR 146/min, BP 100/62, RR 34/min, O^2 sats 98% (CEWT 3). He appeared unsettled, his abdomen was tender but had no localizing signs.He improved with analgesia and was discharged.

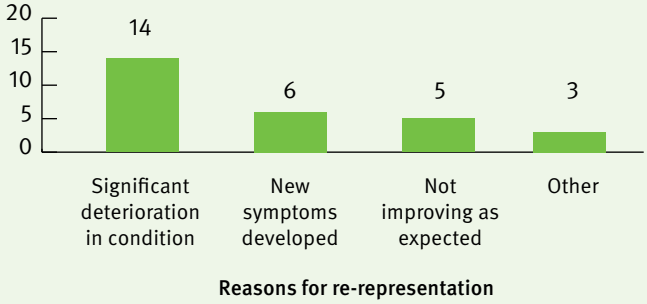
Later that night, Bailey re-presented for a third time with worsening pain and fever. His observations showed clinical deterioration with temp 39.2ºC, HR 156/min, BP 84/55, RR 45/min, O^2 sats 96% (CEWT 6). On examination, there was involuntary abdominal guarding. Imaging confirmed ruptured appendicitis, and he underwent an emergency appendicectomy. *(*Fictional story to illustrate key learnings)*

QPQC Review

The QPQC reviewed 21 paediatric SAC1 clinical incident reports (2018–23), involving unplanned re-presentations to Queensland Health facilities for the same, evolving or related symptoms. Sixteen children re-presented once, five had 2 to 4 re-presentations. Patient outcomes included likely permanent harm (16) or death (5). Final diagnoses included missed/evolving surgical issue (9), sepsis/meningitis (7) and other (5).

Common themes included:

- 15 cases identified diagnostic errors (delayed/missed/wrong diagnosis)
- 6 showed evidence of a differential diagnosis
- 14 had diagnoses reclassified at final presentation
- 8 reported issues with assessment; management/treatment
- 7 cases had limited or incomplete observations, including issues with early warning tool use
- 4 had missed opportunities for direct senior review.



Re-presentations often indicate effective safety netting and parental advocacy. Re-presentations with clinical deterioration require a fresh clinical review of the differential diagnosis.

Lessons Learnt

1. **Re-presentations may indicate deterioration, complications or evolving diagnostic picture.** Children who re-present with pain; new or persistent symptoms; or ongoing concerns should be thoroughly reassessed (including vital signs and physical exam), and a longer period of observation considered. A "one-up" rule for re-presentations, requiring direct review by a more senior clinician is recommended (see Qld Health examples in Useful Links). [1,2]

2. **Reconsider the provisional diagnosis.** Diagnostic accuracy depends on considering/excluding multiple possibilities (differential diagnoses). Be mindful of anchoring bias: avoid fixating on an initial diagnosis, acknowledge uncertainty and remain open to alternative explanations as new information arises. [3, 4]

3. **Inconsistencies matter.** Features that don't fit the working diagnosis should prompt diagnostic review, as they may indicate a more serious or alternative condition.

4. **Document and share your clinical reasoning.** This information can be critical (especially if the child later re-presents). Include your differential diagnoses, likely diagnosis, consistent/inconsistent features, serious conditions excluded, and confidence level.

5. **Take family concerns seriously.** Families often re-present due to unresolved concerns. Their concerns should weigh heavily in decision making.

Useful links and resources

Queensland Health internal resources:

1. Cairns and Hinterland Hospital and Health Service (2025) ED Unplanned Re-presentations - the "One-Up" Rule. Cairns Hospital Emergency Department.
2. Central Queensland Hospital and Health Service (2025) Emergency Department - Unplanned Re-presentations: 'One-Up' Rule.

Other resources:

3. Queensland Paediatric Quality Council (2022) Paediatric Matters. Ed 9 Diagnostic Error: Cognitive Factors and Clinical Reasoning.
4. Singh, H., Connor, D. & Dhaliwal, G. Five strategies for clinicians to advance diagnostic excellence BMJ 2022; 376:e068044 http://dx.doi.org/10.1136/bmj-2021-068044