Highlights from this issue

Martin Ward Platt, *Editor in Chief*

BLENDED FOODS FOR GASTROSTOMY-FED CHILDREN

'Nutritionally complete food'—the sort of stuff that goes down gastrostomy tubes—is only 'complete' in a very reductionist and limited sense. What arrives in the stomach is sterile, which proper food is not, and it does not acquire as much oral flora or saliva as chewed food. It is virtually free of fibre. It is no surprise that the intestinal micro-biome in patients so fed is very different to normal, and possibly pathological. Above all, such feeding has no emotional content: the parental love and care that normally goes into feeding a child is bypassed along with the mouth and oesophagus. So it is not surprising that parents are increasingly resorting to blending normal food and putting it down the gastrostomy tube, thereby using the liquid version of a child's normal diet to mimic as closely as possible the structure and function of mealtimes. The big question for professionals right now is whether this is safe. The more radical question is, might it even be better? Coad *et al* have pulled together a rapid review which summarises the current state of knowledge, and points out the obvious gaps. There is already some suggestion that blended food may be better where there is chronic diarrhoea, and after fundoplication surgery. Some high quality empirical research is now needed to establish advantages and disadvantages unequivocally. I suspect that parents and children will be keen to participate. ***See page 274***

MANAGING CONFLICT

We have carried two previous papers from Forbat *et al* on the topic of conflict, in 2015 and 2016, analysing the sources and effects of conflict between staff and parents in paediatric care. In this edition the group report the results of the next stage: training staff to recognise, understand and manage conflict. The evaluation was not structured as a randomised comparison; it relied on self-report of efficacy at 1 month and 6 months after the training. Despite this limitation, their results are encouraging. Though they have shown that it is feasible and effective to run one-off training sessions, it is intuitively likely that further refresher training might be important for skill retention, as in other domains of education and training. And while the focus has been on conflict between professionals and parents, the taught skills are clearly generic, and might be expected to have other benefits in the clinical workplace when tensions arise between members of staff, but such effects were not measured in this study. Understanding, preventing and managing areas of potential conflict can be thought of as the other side of the coin of shared decision making: if we do one of them better, it helps with the other. ***See page 250***

INFANTS, CHILDREN AND ANTIBIOTICS

The spectre of serious bacterial infection (SBI) stalks any encounter with a febrile infant. Trying to identify the occasional child with an SBI among the many with viral illnesses is hard, so far more children are given precautionary antibiotics than actually have the dreaded SBI. Yet it would be great to be able to admit fewer young children, and give even fewer a course of antibiotics, especially intravenous ones. Over the years many studies have addressed this issue in various countries and in different populations and healthcare systems. Mintegi *et al* report the results of a selective approach in Bilbao, where standardised information was kept on over 1400 infants younger than 90 days with a fever. Just under half of these were classified as low risk and managed with short term observation and without antibiotics, with 5 out of 6 going on to outpatient management. This seemed to work for them. Linking nicely with this, Archivist explores whether antibiotics are over-prescribed on paediatric wards, and Archimedes asks 'What is the risk of a repeat reaction to amoxicillin or a cephalosporin in children with a history of a non-immediate reaction to amoxicillin?' The answer to the first is 'probably often', and to the second, 'probably small'—but see what you think. ***See page 244***

VITAMIN A

Although the association between vitamin A deficiency and mortality is well known, the evidence that vitamin A supplementation improves mortality or morbidity is less clear; indeed the Cochrane review published last autumn found "no convincing evidence that vitamin A supplementation for infants one to six months of age results in a reduction in infant mortality or morbidity in low- and middle-income countries" (doi: 10.1002/14651858.CD007480.pub3). So perhaps Soofi *et al* were not surprised to find no effect of supplementation in their cluster randomised trial in Pakistan. What they did find, which was important, was that it was feasible to use the Lady Health Worker programme to deliver the supplement. The full vitamin A story is clearly incomplete, but one starts to get the feeling that there may be less to vitamin A than meets the eye. ***See page 216***

FAREWELL TO MARK BEATTIE

It was with great sadness that my Associate Editor colleagues and I said farewell to Mark at the end of January after five years as Editor in Chief of ADC. He has been very successful—impact factor up, submissions up, readership and downloads up, international profile enhanced—and he has been a great leader of the team. We will miss his wisdom and inspiration enormously, and wish him well for the future. I am covering his role in the interregnum, until the end of the year.

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