Highlights from this issue

Martin Ward Platt

SHOULD WE SCREEN FOR SCREEN TIME?

'Screen time' means time spent on a computer, games console or television. Nightingale *et al* report data from the Child Heart and Health Study in England (CHASE), which although a bit old (2004–7) are arguably still relevant even though they acknowledge that 'screens' in 2017 would have to include tablets and smartphones. These authors looked for associations not only with fatness, but independently with metabolic risk factors for type two diabetes, such as insulin resistance. Their finding of a strong independent association between screen time and type two diabetes markers, including insulin resistance, with a dose-response in terms of quantity of screen time, is both of interest and concern. It does not prove causality of course, but since exercise is causal for improvements in the factors that collectively make up the risk for type two diabetes, it is reasonable to think that it may be worth evaluating screen time in paediatric consultations with young people, and at least starting a conversation with them about it. ***See page 612***.

HEPATITIS A

Acute infectious hepatitis is rare in children so it was a good topic for a study using the British Paediatric Surveillance Unit. Braccio *et al* report 81 cases, 69 of which were ascertained by the BPSU and another 12 through LabBase2, which were identified during a 12 month window. We now know from their data that hepatitis A is still the largest single identified cause of infectious hepatitis, and that for a third of cases the presumed viral aetiology was not identified. Hepatitis B only accounted for five cases. The annual incidence of infectious hepatitis in children, as a minimum estimate, was approximately 1 in 200 000. The sad thing to my mind was that nearly three quarters of the children with hepatitis A had presumptively acquired it in association with travel abroad, but had not been immunised against it, and if one adds in the five cases with hepatitis B, that's 31 cases (~40% of the study cohort) being potentially preventable. ***See page 628***.

HEPATITIS B & C

With so few cases of childhood hepatitis B and C in the UK, one needs to be reminded that these viruses are still a significant cause of disease and death globally. Around 350 000 000 people are estimated to be infected with hepatitis B, and another 150 000 000 with hepatitis C infection. In two review papers in this edition, Nannini & Sokal have reviewed the current state of hepatitis B and C epidemiology and treatment, and make some interesting points. First, take a look at their global map for hepatitis B. It is salutary to see the extent of high prevalence in Saharan and sub-Saharan Africa, and parts of the far east. Though immunisation and the prevention of mother-infant transmission remain the cornerstone of prevention for hepatitis B, countries such as Russia with a continuing high level of chronic hepatitis B carriage face major challenges. For hepatitis B, immunisation is the big success story, with good progress in relation to anti-viral agents, some of which will also treat HIV co-infection. It's the other way round for hepatitis C: no vaccine available, but some very effective and specific drugs that can cure it. With significant migration globally, we need to be aware of the situation for both viruses in countries from which our patients may have come, or to which they may go. ***See pages 672 and 676***.

GETTING DOSES RIGHT

In hospitals we obsess about medication errors all the way along the chain from prescription to administration. In the outpatient or community setting we prescribe, and hope that children get their medicines appropriately at home, but there is not much published work to tell us what actually happens after that. So it is nice to have two related papers in our Drug Therapy section that address the issue: Solanki *et al* have investigated the nature of medication errors in a specific high risk population of infants discharged home from neonatal care, while Arenas-López *et al* have addressed the very practical question as to how oral syringes perform with different liquids at different volumes. At home, dose administration errors predominated both in terms of amount and timing of administration, and errors were related to the number of medications prescribed, so keeping prescribing simple seems an obvious lesson for us. Given the fact that parents have a number of competing priorities when managing a baby, a household and often other children, these errors should not be a surprise. What we learn from Arenas-López is that we need to bear in mind that volume of medication and syringe size are both important if we are to avoid significant dose errors; and presumably this matters just as much at home as in hospital. ***See pages 655 and 659***.

SYMPTOMS YOU CAN'T EXPLAIN

As every GP knows, the world is full of adults who consult with symptoms for which there is no physiological or pathological explanation, and which are (mostly) not harbingers of serious disease. Indeed such symptoms are widespread in the population, but only a selection of people consult about them. A few make their way through to secondary care and become at high risk of undergoing invasive investigations. But what about children? Græsholt-Knudsen *et al* do not tell us what to do when young school-age children are brought with such symptoms, but they do tell us quite a lot about what happens to them: in Denmark at least, they become high healthcare users, with a significant health economic impact, while they are still pre-pubertal children. Re-framing the illness behaviour of their parents might seem to be the obvious intervention, but who should try to do this, and how, is not so clear. ***See page 621***.