

Palliative Care In Children

Palliative care is expanding as a clinical service. Despite the pioneering work of Kubler-Ross in the 1960s, which culminated in the publication of her book *On Death and Dying* in 1969, and the development of palliative care models as part of cancer care, particularly in children, little systematic data are available about palliative care. Taylor *et al* provide a glimpse of such care at the Martin House Children's and Young Person's Hospice Spa, in North Yorkshire. Over the 20 years that Martin House has been opened, the number of children who have received care has risen dramatically, from 133 in 1984–88 to 334 in 2004–2008. The average age of referral has declined from 8.21 years to 6.87 years. The children are classified according to the Association of Children's Palliative Care (ACT), which includes four categories: group 1—life-threatening conditions for which curative treatment may be feasible but can fail (eg. cancer); group 2—conditions in which premature death is inevitable (eg. cystic fibrosis); group 3—progressive conditions without curative treatment options (eg. muscular dystrophy); and group 4—irreversible but non-progressive conditions causing severe disability (eg. severe cerebral palsy). In my conversations with a number of colleagues who work in this area they struggle with one other important parameter which is not well captured by ACT—the rapidity with which some children die. In many countries, more children die from traumatic events, like motor vehicle accidents, than from chronic conditions. Many very premature infants die before they enter a palliative care system. The question is what defines palliative care and whether it should be expanded to include the care of a patient and family, regardless of the cause or speed of death. *See page 89*

Should countries institute universal newborn hearing screening?

Screening entire populations is complicated, involving careful consideration of cost, ability to provide definitive diagnostic testing for those who screen

positive, good evidence that early detection improves health outcomes, and finally consideration of the financial and emotional consequences of “false-positive” screens. Both Great Britain and US endorse newborn hearing screening programmes. Interestingly the US differs from much of Europe with respect to screening athletes for cardiovascular disease. Neither the American Heart Association nor the American Academy of Pediatrics endorses a screening ECG for athletes. The US decision is based in part upon concern of overwhelming our health care system with referrals to paediatric cardiologists—a rare consideration in the US. In this issue, a report from the Institute for Quality and Efficiency in Health Care, the German equivalent of NICE, presents the result of a systematic review of the accuracy, effectiveness, and effects of interventions after newborn screening. They conclude that there are limited data about the long term impact of screening on many patient-relevant parameters. Recently the U.S. Preventive Services Task Force, an agency similar to NICE, changed their recommendation and endorsed universal screening largely because of the work of Colin Kennedy and his group from Southampton (1). It is clear that either otoacoustic emissions or auditory brainstem response can be used to assess newborn hearing. The more important issues are whether a programme is equipped to provide a definitive diagnosis, and then refer the infant for appropriate services. *See page 130*

The use of aciclovir in children

There has been a dramatic decline in the incidence of bacterial meningitis following the introduction of both the Haemophilus Influenzae and pneumococcal conjugate vaccines. Concomitant with this decline has been the growing use of aciclovir in infants and children. The common presentation of fever, irritability, and seizures in children often leads to consideration of encephalitis as the diagnosis. Herpes simplex virus type 1 is the commonest diagnosed cause of encephalitis in children in the UK and treatment reduces mortality. In an audit from the Alder Hey, Kneen *et al* identified 51 children treated over a six

month period for suspect viral encephalitis. Their major findings: the initial dose of aciclovir was incorrect in 38 children and 32 children never had a CNS sample obtained. They also write that 14 children had no real indication for aciclovir, but I am always concerned when case notes are used to make such judgments. Hindsight is usually 100% accurate. Whenever I read audits such as these my initial reaction is that we do better at my institution. However, before jumping to that conclusion I should obtain some data! *See page 100*

Preventing the death of children

The death of so many young children around the world from preventable causes remains an abject failure of government. Nicholas Kristoff, in a provocative essay in the *New York Times* (November 22, 2009, <http://www.nytimes.com/2009/11/22/books/review/Kristof-t.html>), explores a number of competing views on this issue. He discusses four books, *The End of Poverty*, by Jeffrey Sachs, which suggests that it is just a matter of money and that countries must be more generous (particularly the United States). The counter argument is offered by William Easterly in his book *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done So Much Ill and So Little Good*. He explores the failure of aid to be of much help in improving the health and well-being of children and adults, and suggests that a different approach is required. Kristoff goes on to site a new book this year from a Zambian economist, Dambisa Moyo, titled *Dead Aid: Why Aid Is Not Working and How There Is a Better Way for Africa*. Ms. Moyo has attracted substantial attention because she is an African denouncing aid to Africa. Kristoff concludes by noting the work of Paul Collier, from Oxford, in *The Bottom Billion*, who he believes offers up a synthesis of ideas which includes aid directed both at health issues and economic development.

REFERENCES

1. Kennedy CR, McCann DC, Campbell MJ, et al. Language ability after early detection of permanent childhood hearing impairment. *N Eng J Med* 2006;**354**:2131–41.