Highlights from this issue

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Skinning cats for a living

Let's kick off with an aphorism fit for this most ascetic of months.

> The scholar who cherishes the love of comfort is not fit to be deemed a scholar (Confucius c 500 BC).

Surely, 'the love of comfort' Confucius alludes to is dogma. I'm allergic to the 'it must be so' school of thought (more on IgE-related matters later), which plagues medicine as much as any other walk of life. How refreshing, therefore, to introduce a crop of papers that either challenge dogma or chronicle its demise.

Idiopathic thrombocytopenic purpura

Little more than 20 years ago, any child with, even mild, idiopathic thrombocytopenic purpura (ITP) would have been subjected to not only invasive investigation (a bone marrow aspiration at least) but also to a prolonged inpatient stay, enforced bed rest and high dose steroids until an arbitrary threshold value for a safe platelet count had been transcended. Grainger's analysis of trends in ITP management in the UK, over an era straddled by evidence-based recommendation, illustrates a shift in practice towards conservative management on the basis of need rather than numbers. I'm well aware that I bore trainees with my efforts to dissuade them from carrying out unnecessary tests or procedures so this paper gives me extra, vicarious, pleasure. ***See page 8***

Shared care

Rather more provocatively, Doull and Evans' paper on differences in outcome in Welsh children with cystic fibrosis by model of care received is bound to ruffle feathers. Shared care systems (secondary care based, tertiary augmented) have long been held at least comparable clinically and superior logistically and socially to their pure tertiary siblings. In this study, however, despite baseline equivalence at 9 years of age (with the rider that pulmonary function was not assessed), predicted FEV1 (though not other markers) was significantly lower by early teenage in the shared care children. Whether these results ultimately prove to be a statistical quirk of multiple comparisons, explicable by residual confounding or only a short term deviation it will force a re-examination of this particular sacred cow in the interim. ***See page 17***

Food phobia

Gluten certainly features highly in the culpability charts for ailments from fatigue to school under performance and I was therefore intrigued by Tanpowpong and colleagues' New Zealand study. They showed a prevalence of active gluten avoidance, five times greater than that of serologically or histologically diagnosed coeliac disease. 'But there's no evidence for doing this' we imperceptibly sigh in outpatients. The corollary of course is that there might, just might be, albeit intangible, a benefit that the hallowed tests of our generation are too blunt to detect. Maybe we're all guilty here of narrow mindedness……of dogma even…

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A silent epidemic

Balan and Lingam's review of accidental/unintentional injuries (UI) in resource-poor settings makes sobering reading. Their review shows UI-related mortalities more than three times higher than in well-resourced settings and, although the majority are due to similar causes (burns and falls), the even greater excess mortality from drowning, pedestrian road traffic accidents and paraffin poisoning paints the dearth of appropriate legislation in a stark light. This, the insouciance, is the real crime, and until individual accountability becomes the norm, meaningful change simply won't take place. ***See page 35***

Child health surveillance

Bellman and Vijeratnam chronicle the chequered history of child health surveillance. The scheme, initially intended as a primary care administered programme at its unveiling in the 1970s never really passed the criteria for the screening test it aspired to be. It subsequently found new incarnations in targeted screening, child health promotion and, now, the nascent rather jingoistic 'Healthy Child Scheme'. The final destination is unclear and doesn't seem anywhere close as it has become something of a political punchball. ***See page 73***

RCPCH allergy pathways

Just released online, the new Royal College of Paediatrics and Child Health (RCPCH) allergy pathways[1] (care pathways for children with allergies: an RCPCH project) demand attention. These were originally commissioned by the Department of Health as a response to the still-increasing prevalence of allergic disease, often unfocused and ineffective service provision and, as a result, great health service expense.

The pathways (http://www.rcpch.ac.uk/allergy) were drawn up by expert panels led by John Warner at Imperial College and, at their core, are designed to unify management. There are eight pathways in total, the work of six subcommittees including: anaphylaxis; food allergy; asthma and rhinitis; eczema: urticarial and drug, venom and latex allergy. Continued momentum long term will depend at least partly on funding; a prosaic detail that would never have concerned Confucius.

This month in *F&N*

- Does clinical practice on a national level inform us about transcultural character traits? I don't pretend to know but was intrigued by Klingenberg's survey of neonatal unit feeding practices which showed a markedly more cautious approach to the rate of milk introduction in New Zealand, Australia and Canada than that in the UK and Scandinavia. I have to differ with the authors' concluding exhortation that 'more research is needed'. To me the simple bottom line is that there are many ways of skinning a cat….Isn't that so often the case when the dust settles..? ***See page F56***

REFERENCE

1. Royal College of Paediatrics and Child Health. Care pathways for children with allergies: a Royal College of Paediatrics and Child Health (RCPCH) Project. http://adc.bmj.com/content/96/Suppl_2.toc (accessed 6 Dec 2011).

Happy New Year.