



CrossMark

Highlights from this issue

R Mark Beattie, *Editor in Chief*

IMPACT OF EARLY LIFE FACTORS ON INEQUALITIES IN RISK OF OVERWEIGHT IN UK CHILDREN

Childhood overweight and obesity is more common in disadvantaged children, but it is unclear the extent to which early life factors attenuate this relationship. Massion *et al* explore this using data from the UK millennium cohort study (11,764 children). At age 11 years 28.4% were overweight (combining with obesity). Maternal academic qualification at the child's birth was used as a fixed measure of socio-economic circumstance. Children of mothers with no academic qualifications were more likely to be obese than children of mothers with degrees and higher degrees (RR 1.72, 95% confidence interval 1.48–2.01). Controlling for prenatal, perinatal and early life characteristics (particularly maternal pre pregnancy overweight and maternal smoking during pregnancy) reduced the risk (RR 1.44, 95% confidence interval 1.23–1.69). This study confirms the social gradient in obesity risk but also specific early life risk factors that at least partially account for this. The authors call for initiatives and policies to support mother's maintain a healthy weight, breast feed and abstain from smoking during pregnancy to improve maternal and child health outcomes, and potentially impact on the continuing rise in inequalities in childhood overweight. *See page 724.*

WHO COMES BACK WITH WHAT: EMERGENCY READMISSIONS

More than 30% of children and young people who have an emergency admission will have at least one further admission in the following 2 years. Recurrent admissions make up 41% of emergency admissions and 66% of bed days. Wijlaars *et al* explore the question—are readmissions for the same condition? The authors use national administrative hospital data. From the primary diagnosis admissions are coded into 6 groups—infection, chronic condition, injury, perinatal associated, pregnancy related or other. Emergency readmission within 30 days occurred in 9% and between 30 days and 2 years in 22%. Half of the 30 day readmissions and 40% of the recurrent admissions between 30 days and 2 years were for the same condition—consistent across age groups apart from infants (infection) and young women with pregnancy related conditions who were more likely to be admitted for the

same diagnostic group. In children with chronic conditions readmission was significantly more likely (RR 1.93, 95% confidence interval 1.89–1.99). The authors emphasis that if a significant number of readmissions are either with a different condition or in children with chronic health problems then the presumption that financial penalties for readmission incentivise more effective care of the original problem should be challenged and more specific datasets sought. *See page 714.*

IS ASTHMA OVERDIAGNOSED

The National Institute for Health and Care Excellence (NICE) has recommended that clinicians should seek more objective evidence before making a diagnosis of asthma. Under diagnosed in the past but have we gone too far in the opposite direction? In a leading article Bush *et al* explore some of the detail. The potential cost of over diagnosis is not trivial. Does everyone with a chronic cough have asthma—clearly not. The difficulty is how objective the testing should be. There are some core principles including a detailed history and examination and a detailed knowledge of the differential diagnosis (which includes normal). There should be evidence of variable airflow obstruction, at least in the school age children, before contemplating an asthma diagnosis. If therapeutic trials of treatment are to be performed, then they should be focussed and time limited and children should not be left on unproven treatments. The authors make the point that physiological testing in the school age child is available at all levels of care. The complexities (and practicalities) of the less straightforward patients are discussed including the potential for more detailed testing, electronic compliance monitoring and anti-inflammatory therapy. This is an important article to read and consider and Editor's choice this month. *See page 688.*

MORAL DISTRESS WITHIN NEONATAL AND PAEDIATRIC INTENSIVE CARE UNITS

Moral distress refers to the anguish experienced when an individual makes a clear moral judgement about what action he/she should take but is unable to due to constraints (societal, institutional or contextual) with moral residue being the lingering feelings that remain once the morally distressing situation

has passed. These are challenging concepts. Modern intensive care units are high pressure environments where technology creates potential for burdensome care with limited perceived benefits in vulnerable populations. Prentice *et al* review the literature. There are few studies (13) with less than half being multidisciplinary and most looking at nursing responses. Common themes identified were 'burdensome' and disproportionate use of technology perceived not to be in the patients best interest, and powerlessness to act. Nurses are often portrayed as victims with physicians seen as perpetrators instigating 'aggressive care'. Medical literature describes moral distress in terms of dilemmas or ethical confrontations. There is a need for more to be written about this—these patients are cared for by large multidisciplinary teams—and longitudinal data reflecting the views of all stakeholders (including parents) are required. There is a sensitive and thought provoking editorial written by David Field and colleagues. *See pages 701 and 686.*

POVERTY AND CHILD HEALTH IN THE UK

Child poverty is associated with a wide range of health damaging impacts, negative educational outcomes and adverse long term social and psychological outcomes. Wickham *et al* outline some key definitions with regard to child poverty, review the links between child poverty and a range of health, developmental, behavioural and social outcomes for children, describe gaps in evidence and provide an overview of current policies relevant to child poverty in the UK. Child poverty in the UK has started to rise—measured as household income less than 60% of the median. UK data from Public Health England shows a clear relationship between child poverty and infant deaths, serious injuries from road traffic accidents, hospital admissions for mental health conditions and obesity. Children living in poverty in the UK are more likely to be born small, be bottle fed, breathe second hand smoke, suffer from asthma, have tooth decay and perform poorly at school. The authors call for child health professionals to support policies to reduce child poverty, provide services that reduce the health consequences of child poverty and work to measure and understand the problem and assess the impact of action. *See page 759.*



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