

IN MEMORY OF DR BARBARA ANSELL

Barbara Ansell was a remarkable doctor who put paediatric rheumatology as a speciality on the map in the UK starting her work more than 50 years ago. She was known internationally for her classification of juvenile arthritis, research, and lecturing. Following her death more than a year ago it was decided that *ADC* should pay a tribute to her.

Accordingly Dr Richard Hull was invited to be Guest Editor for a special series of four rheumatology articles on new advances in treatment that I hope you find stimulating. They start with biological therapies move to intra-articular steroids then systemic methotrexate and finish with stem cell transplantation. The range and diversity of Barbara Ansell's interests can be seen from early work on ACTH effects on growth, epiphyseal stapling for valgus deformities published in *ADC* in 1971, and bone density studies in Still's disease in 1985.

See pages 185–205

WHAT'S NEW IN IMMUNISATION?

Does pneumococcal vaccination reduce nasopharyngeal carriage of the organism several years later? Lakshman *et al* have looked at this after heptavalent conjugate pneumococcal immunisation. They have shown that in contrast to Hib vaccine, which leads to dramatic falls in Hib nasal carriage, the initial response of reduced nasal carriage rates of pneumococcus seen in infancy did not persist with the former. These findings are intriguing, as other studies have not shown any waning effectiveness in prevention of systemic pneumococcal disease from the conjugate vaccine.

In another article Heath *et al* looked at whether Hib vaccine works in premature babies. Their findings are reassuring as although they show lower protective antibody levels in preterm compared with term babies the immune

response was still excellent. National epidemiological figures from the British Paediatric Surveillance Unit (BPSU) showed only 18 cases of invasive Hib disease in premature babies over an 8 year period. Parents and paediatricians can be confident that the advice to give the immunisation for premature babies routine schedule is satisfactory.

Opponents of MMR immunisation make more and more bizarre claims. Many of these theories appear in unconventional scientific outlets such as radio, television, magazines, or newspapers—perhaps because the authors rarely feel that their theory or research is likely to survive the rigors of the peer review process.

Is there an increased risk of bacterial infection or chest infection in children following MMR immunisation? Miller *et al* have looked into this and showed no increase in invasive bacterial infection but interestingly a reduced incidence of lobar pneumonia. No evidence or support is given to the “immunological overload” theory; indeed their interesting preliminary findings of reduced chest infection risk in the months after MMR vaccination need looking into in more detail in the future.

See pages 206, 211, and 222

HOW TO REDUCE RESPIRATORY ILLNESS

An Australian study from West Perth of 2456 infants has shown a reduced prevalence of respiratory illness in babies predominantly breast fed for more than 6 months or partially breast fed up to a year. Additionally these two groups had a reduced rate of hospital admission and wheeze compared with their bottle fed counterparts in the first year of life. Here is more data to encourage breast feeding.

Soussan *et al* from Paris have looked at the effect of passive smoking on asthma control. Their prospective study of 167 children showed that adequate control of asthma was less likely to be achieved if the mother smoked at home. Careful history taking and appropriate counselling needs to be offered to families where there are smokers at home (even if smoking appears to be at the end of the garden!)

A case report reminds us that infants with congenital adrenal hypoplasia may present with respiratory symptoms in the first few weeks of life. If the respiratory illness is unexplained, the parents consanguineous, or there is hypoglycaemia at term, or hyponatraemia/hypokalaemia an urgent cortisol may give the answer.

See pages 224, 229 and 261

HOW COMMON IS PRADER-WILLI SYNDROME?

As more treatment options become available for this group of children who can now have their clinical diagnosis confirmed genetically, so the importance of early secure diagnosis increases. Many of these infants present with profound hypotonia as newborns but naso-gastric tube feeding in term babies for no apparent reason, suspicious facies, failure to thrive followed by excessive weight gain should all lead the paediatrician to send off specific genetic blood tests to their regional genetics laboratory. Smith *et al* from Sydney give the first population based prevalence figures of 1 in 25 000 live births per year. This must be regarded as a minimum figure because there are still ascertainment problems.

See page 263. See also Archivist on page 210

SEDATION OR ANAESTHETIC?

Sedation with oral or nasal midazolam is widely used for painful procedures. Crock *et al* from Parkville, Australia have looked at children with cancer and compared general anaesthetic with sedation. High rates of restraint (94%) were needed with sedation compared to only 4% in children receiving an anaesthetic; the latter group had low levels of pain and distress. In this specialised group of children there are clear benefits but the issue needs attention in other groups of children.

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