Colonic transit times and behaviour profiles in children with defecation disorders

H Marcovitch

Commentary on the paper by Benninga et al

When the editorial committee discussed whether to accept the paper by Benninga et al for publication, some members raised concerns over the propriety of undertaking rectal manometry on children with abdominal pain. In response, the authors promptly provided their correspondence with the appropriate ethical committee (institutional review board). These revealed that the authors had properly obtained approval for the investigation in constipated children, their siblings (following fully informed consent), and those undergoing endoscopy for other conditions.

We accepted the authors' explanation that the children with a prime complaint of abdominal pain had been referred to their specialised dysmotility clinic. The inference is that those referring the patients considered their pain might be due to constipation.

They wrote: “... in our outpatient clinic, the standard work-up for all children with functional defecation disorders or functional abdominal pain (irritable bowel syndrome or recurrent abdominal pain) includes a thorough medical history and complete physical examination, colonic transit studies, and rectal barostat studies.”

A related issue was raised recently in the correspondence columns of Thorax concerning a paper detailing bronchial biopsies performed, as a research procedure, on children with asthma whose prophylactic medication had been discontinued for the preceding month.

Bush and colleagues pointed out that bronchial biopsy would be included among those high risk procedures which the Royal College of Paediatrics & Child Health considers unjustified for research purposes alone. The investigators, who practice far from the guiding light of the RCPCH, responded that informed consent was received from parents (they did not state whether children consented) and that, in any case, they watched the children closely with a view to exclude any disadvantage by cessation of prophylaxis.

So here is the dilemma: research projects require ethical committee approval while standard clinical practice may require only informed consent. In the case of the paper published in this issue, it seems that at some point research had elided seamlessly into routine practice. Once a procedure becomes part of a routine clinic work-up then it is presumably no longer a research project. In the case of the Thorax paper it appears that research regarded in one country as requiring ethical committee approval demands only parental consent in another.

We decided to publish the paper by Benninga et al because it contains valuable information for our readers and we accept there are grey areas, especially in tertiary care, as between research and standard clinical practice. I doubt that we would have published the Thorax paper.

I no longer write as editor, but I know that ADC does not intend to soften its line, but rather strengthen it, when it comes to ethical standards. During 2002, five papers submitted to ADC ended up being reported (after rejection) to the Committee on Publication Ethics (www.publicationethics.org.uk). We have passed on our concerns about four of them to the appropriate head of department or chief executive, asking him or her to mount an enquiry. We are likely to do the same about an alleged attempt at duplicate publication which we are still investigating.

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