

# Atoms

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## TREATING CHILDREN WITH ASTHMA

Treating children with asthma has become increasingly difficult, although admittedly I do not have fond memories of measuring and adjusting theophylline levels in the 1970s and 1980s. Currently, virtually all guidelines for the treatment of children with persistent asthma mandate the use of inhaled corticosteroids (ICS). While in the past there were only a limited number of ICS, now there are many preparations available, all coming in different strengths. Masoli and colleagues from New Zealand present the results of a systematic review of the efficacy of inhaled fluticasone propionate, suggesting a dose-response relationship that plateaus between 100 and 200 µg per day. In an accompanying perspective, George Russell comments on two critical aspects of asthma management—adherence and titration to the lowest effective dose of ICS. Many questions remain. For example, at what dose of ICS should leukotriene receptor antagonists or long acting β<sub>2</sub> agonists be added to “spare” the steroid dose? How do we manage children who only wheeze 3–4 months a year, and who during that time clearly have persistent disease, but for the remaining part of the year have intermittent disease? In my experience, very few parents are willing to (nor should they) give their child ICS for the entire year. Finally, does long term follow up of 3–5 years really indicate that ICS are safe? I remain concerned about children, particularly girls, who potentially will receive ICS for decades. Will they be more likely to develop osteoporosis?

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## COLIC – IS TINCTURE OF TIME THE ANSWER?

Over time colic resolves in most infants — or at least that is the common wisdom. Researchers from Women and Infants Hospital in Providence,

Rhode Island suggest that disorganised feeding and sucking are far more common in infants with colic than in normal infants. Can we help these infants (and their parents)? Is there a simple, reproducible intervention or is the disorder so heterogeneous that no one approach is likely to be successful? Are there lingering effects of colic? As these infants mature do they “outgrow” colic or do the disorders noted in this study evolve into other problems? Some of these questions have been answered, but others await further research.

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## THE RELIABILITY AND VALUE OF THE PHYSICAL EXAMINATION

One of my mentors, Dr Joel Alpert, always recalls the year he spent at St. Mary’s in London quite fondly. He talks passionately about learning the value of physical examination. In two reports from Kenya, the reliability and validity of the physical examination are explored. Unfortunately, Otieno and colleagues suggest that agreement among experienced clinicians regarding capillary refill time, temperature gradient, pulse volume, and signs of dehydration (including dry mucous membranes, decreased skin turgor, and sunken eyes) is modest at best. In contrast, Pamba and Maitland suggest that in children admitted to hospital with malaria, gastroenteritis, or malnutrition, delayed capillary refill time has significant prognostic value, differentiating between children who will survive and those who will die. On occasion, after I listen to our residents present patients during morning rounds, and I hear all of “the numbers” (Is and Os; vital signs, including the ubiquitous O<sub>2</sub> saturation level) and the long list of medications, I remain unclear how sick the child is and ask (often with some distain in my voice) “can you just tell me in plain English what the child looks like!”

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## DIAGNOSING AND TREATING ADHD IN THE UK

The evaluation, diagnosis, and treatment of children with attention deficit/hyperactivity disorder (ADHD) have provoked a great deal of criticism on both sides of the Atlantic. McKenzie and Wurr report the results of a survey of child psychiatrists and paediatricians who routinely assess and treat children with attentional difficulties. Unfortunately, there is always concern about whether practice is accurately represented in response to questionnaires, particularly when they contain no clinical vignettes. Nevertheless, the answers are illuminating. Both groups routinely obtain information from schools, but neither group routinely requests a psychometric evaluation. Child psychiatrists are significantly more likely (41%) to tightly apply diagnostic criteria than paediatricians (13%). Both groups will sometimes use stimulant medication without a formal diagnosis. The majority of parents are thought to have a preconceived notion that their child has ADHD, and the vast majority of both parents and schools are felt to pressure—at least sometimes—doctors to prescribe stimulant medication. What do these results tell us? First, despite the proliferation of guidelines and recommendations for the “proper” evaluation of children with possible ADHD, physicians feel some urgency to medicate children before the evaluation is complete. Because of increased attention in the media, ADHD is more familiar to parents and teachers, and so more clinicians pressure to diagnose ADHD and prescribe stimulants. Having patients drive *evaluation* for specific disorders is consistent with patient centred. Hopefully patient empowerment does not drive diagnoses.

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