Atoms

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The history of *ADC*

The digital age has truly arrived at *ADC*. We blog, have RSS feeds and have begun podcasts. Now, courtesy of the National Institutes of Health (National Library of Medicine) the entire collection of *ADC* is available at http://adc.bmj.com/contents-by-date.0.dtl (last accessed 9 April 2009). Between 1926 and 1937, *ADC* was published six times each year. During the war years, 1938–1950, four issues appeared annually. Between 1951 and 1972 we returned to six issues. Since then, *ADC* has appeared monthly. *Fetal and Neonatal* joined the family in 1994 and *Education and Practice* in 2004. Searching the Archive can be done by issue, subject, title or author, with the article in PDF format just a couple of clicks away. For example, the first research publication of each of RCPCH presidents can easily be found. They are:

- Professor David Baum (1997–1999) – Retinal photography in the newborn, 1969
- Professor Richard Cooke (1999–2000) – Factors associated with periventricular haemorrhage in very low birthweight infants, 1981
- Professor Sir David Hall (2000–2003) – When does secretory otitis media affect language development, 1986
- Professor Sir Alan Craft (2003–2006) – The ''grey toddler''. Chloramphenicol toxicity, 1974
- Dr Patricia Hamilton (2006–2009) – Congenital erythroid hypoplastic anaemia in mother and daughter, 1974
- Professor Terence Stephenson (2009-) – Atrial natruiuretic factor: the heart as an endocrine organ, 1990.

Enjoy this new resource, it makes looking at ''history'' much easier.

ADC grows again

In January, Imti Choonara and I announced the addition of Drug Therapy to *ADC*.[1] We consider a number of issues when we add content, or engage in new activities. First, will it be appealing to our readers. In this case, as our therapeutic options increase in paediatrics, understanding new drugs is increasingly important. Second, is the content linked to improving child health? Fi Godlee, Editor of *BMJ*, has said many times that she wants our journals to help physicians make decisions that improve patient outcomes. I concur with this statement. Third, adding new modes of communication reflects our appreciation that our users have varied reading habits. Some of our readers like print, others are increasingly married to the internet, and still others like to engage in more contemporary forms of communication like RSS feeds, blogs or podcasts. Our goal is to provide our readers with a potpourri of options so they can best decide how to access *ADC*.

In this issue is the first actual collection of Drug Therapy, along with an introductory editorial from Professor Choonara. The article types in this new section will be familiar to our readers, and will include, perspectives, reviews and original articles. We are hoping to publish four times each year, and when content is sufficient, to have Drug Therapy published separately, similarly to *Fetal and Neonatal* and *Education and Practice*. ***See pages 467–83***

Screening for hypercholesterolaemia in children

Harry Baumer began writing our guideline column four years ago. I am delighted that this new article type has now been adopted by many other journals. It is helpful to have an expert clinician summarise what are often long and confusing reports, commenting on their clinical importance. For many of us reading an entire guideline is often tedious. In this issue of *Education and Practice*, Drs Baumer and Shield, review the NICE and AAP guidelines for cholesterol screening in children. Whereas the US approach is quite aggressive, recommending screening all high-risk children every five years beginning at age two, which would lead to about 60–70% of US children being screened, the NICE recommendations are more restrained. There has been a great deal of concern in the US that the recommendations are too aggressive, since they may lead to many more children and adolescents being started on statins, and we know little about their long-term safety. Why the difference between the two sets of recommendations? I suspect the US recommendations are driven by concern about the obesity epidemic, the accumulating data that the effects of elevated cholesterol are evident much earlier in life than once believed, and the safety profile of statins in the adult population. ***See page ep83***

Epistaxis in infants

Epistaxis in infants is rare. In a case-series from Cardiff, over a six-year period 36 confirmed cases were identified. The majority of children (23), had a recognised cause, including trauma, coagulation disorder, congenital anomaly, acute rhinitis, or smothering. No cause was identified in 13 children, although coagulation disorder was excluded in 7. The authors conclude that a bleeding disorder should always be considered, unless there is an obvious cause, and ''if additional evidence suggests physical abuse, this must be excluded.''

Quality in healthcare

Everyone wants their money's worth. In healthcare this means, given the relentless increase in healthcare spending in virtually every country, are people healthier–leading more productive lives and living longer? Kavanagh and colleagues from the US review quality indicators and quality assessment in child health. They briefly review the quality movement in healthcare, explore the world of quality indicators, and then provide examples of quality indicators in children and also provide two useful taxonomies. They found that 5% of quality indicators focus on treatment, followed by diagnosis (26%) and screening (22%). Unfortunately, the vast majority focus on process (97%), rather than true health outcomes (3%). Since the link between process and outcome is not always clear, refocusing our efforts to measure true health outcomes is likely to improve child health.

Reference

1. **Choonara I,** Bauchner H. Publishing the evidence for children's medicine. *Arch Dis Child;*2008;**93**:815.