

Can the environmental movement impact adversely on child health

There has been substantial interest in reducing all types of plastic, particularly bags and bottles. Although plastic bottles can be recycled, in many countries they become part of land fill. McLennan describes an increasing reliance on bottled water as a way to ensure clean water for children living in a poor community in the Dominican Republic. They do not specify whether the water was in glass or plastic, but I suspect plastic was the prevailing container. Is there a conflict between improving the health of children (providing clean water) but the goals of the environmental movement (eliminating plastic)? There are other examples of this conflict, for example the use of pesticides to control insects or improve crop production. Balancing the needs of children and the protection of the environment is a 21st century dilemma *See page 898*.

A simple question: an important answer

In a report from Glasgow, Meghomala Das and colleagues ask an important question – can children with physical disabilities attending school see properly? They assessed the vision of 190 of 240 children who were able to cooperate with screening. Their findings – 12.1% of the children were found to be visually impaired according to WHO criteria. Only half of the children who required correction because of a refractory error were wearing proper eye glasses. The implication of this story – all children with complex needs and/or physical disabilities must have their vision assessed. Although I champion randomised clinical trials and systematic reviews, the answer to a focused question can have enormous implications for health care. During my fellowship in clinical investigation I remember the constant refrain from my mentors – what is your question, what is your question! *See page 888*.

Twin reports on Henoch-Schönlein Purpura

Two papers from one group in Finland report on 223 children with HSP. The

first describes the presenting signs and symptoms in children newly diagnosed – joint or gastrointestinal complaints, followed by arthritis and arthralgia, melena, and nephritis. Only 3% of patients developed protein-losing enteropathy, characterised by oedema and low serum albumin. Patients with severe HSP nephritis were more likely to develop extrarenal symptoms during the six month follow up period. In the second paper, they report that 46% of the children developed some evidence of nephritis. The risk of developing nephritis after 2 months was only 2%. Risk factors associated with nephritis included older age, abdominal pain, and recurrence of HSP. The authors recommend weekly urinalysis for the first 2 months following diagnosis. In neither report did the use of steroids impact the long-term outcome. What do these reports tell us? First, children who are “sicker” when they are diagnosed with HSP are more likely to develop multi-system disease – this is not surprising. Second, very few patients will have long-term problems. And although steroids were not formally assessed in this study, they appear unnecessary in children with mild disease. Interestingly, I have seen fewer cases of HSP at my hospital in the past 5 years. I suspect that the genetic profile of a child plays a role in disease manifestation. Lastly, from a publishing standpoint, a number of the associate editors and I debated whether these data should be reported in 1 or 2 papers. We decided on two. I am still not sure it was the correct decision *See pages 871 and 877*.

Sustainability for programmes in low and middle resource countries

Some experts in global health have argued that little additional research is needed to substantially reduce the number of children under the age of 5 who die each year. The critical issue is one of implementation and sustainability. In a remarkably honest report from Alison Earley in Nottingham she describes her struggles with a program that she has helped to develop that focuses on

treating children with Burkitt lymphoma in Cameroon. She describes the success of this programme, but acknowledges that the critical issue is one of sustainability. Currently the programme relies on donors to survive – Cameroon does not have the resources to support the program. The idea of “twinning” – matching a program in resource-rich countries with a program to treat children with specific diseases in low and middle resource countries – is not new. In general these programmes have avoided diseases that require highly intensive services, such as AML in favour of conditions like ALL or Burkitt lymphoma where the prognosis, with a modest investment, is generally quite good. However, regardless of the programme or the disease, sustainability remains a huge hurdle *See page 920*.

Report of child maltreatment in England

In a rather complex study that was based upon administrative data, González-Izquierdo and colleagues from UCL report that the incidence of admissions for maltreatment syndrome (child abuse or neglect) and maltreatment-related features (assault, undetermined cause or adverse social circumstances) have remained stable between 1997–2009. The use of administrative data to track diagnoses such as these can be problematic. It is quite possible that “admission” criteria for these two conditions have changed over the decade, so that children who would have been admitted with diagnoses consistent with maltreatment syndrome in 1997 were not admitted in 2009. They comment that the rate of maltreatment which they found is substantially less than that reported in the US. For example Leventhal found that in the admission rate for fractures consistent with abuse was 36.1/100,000 which is twice what they found, 13.4/100,000. They speculate that there are three possible explanations: (1) rates of abuse are lower in the UK; (2) recognition is poorer in the UK; or (3) that UK physicians maybe hesitant to code/report diagnoses which suggest abuse *See page 918*.