Warning systems and ethics
I can’t remember an issue of Archives with greater breadth in every sense: geographical; biomedical and philosophical. Once assimilated, though, two distinct themes became clear; warning systems and ethics within child health which share similar uncertainties.

Screening systems for adverse outcomes invariably entail difficult decisions; the trade off between over ‘identification’ of pathology, poorer specificity and greater economy with the risk of missing real cases, poorer sensitivity. Three papers demonstrate the tension in different ways.

Three further papers, examine ethical equipoise from different angles: new techniques for previously incurable disease; the legal nuances of parental responsibility and the unique vulnerability of adolescents.

Finally, congratulations are due to Hilary Cass. Every 3 years, the Royal College of Paediatrics and Child Health conducts elections for a new president. Just before writing Atoms, the results from this year’s poll were announced and Hilary will be taking over next spring from Terence Stephenson. A great achievement against a strong field.

Signs of severe illness in young infants
Millennium Development Goal 4 (the reduction of child mortality by two thirds of the 2000 level by 2015) though imminently achievable relies on the recognition and prompt treatment of severe illness. There is now a substantial body of literature on warning signs in both developed and resource limited settings complete with its own glossary of terms. Opiyo and English have synthesised the evidence and condensed the key signs. Most of the current available systems which range in ease of administration use a combination of these with other signs so there is some consensus. Apart from health worker recognition, there are further tantalising obstacles familiar to anyone with experience in these settings: the logistics of referral and, even more fundamentally, parental recognition that their baby is ‘not right’ and presentation at a health facility. This might prove the hardest step. See page 1052.

Nutrition
Two papers from opposite ends of the malnutrition spectrum discuss new tools. Rudolf and colleagues elegantly model an obesity risk prediction tool using a composite score derived from recognised risk factors. It is hypothetically attractive, conceptually much like weight faltering charts and could reasonably be incorporated into the parent held child health record. Like any screening programme, there are downsides associated with the lack of specificity including generating unnecessary anxiety and the risk of inappropriate ‘diets’ for young children. It was, however, well received by the participating parents and health visitors so passes two important tests. If it passes into mainstream circulation it will be interesting to watch its evolution at public health level. See page 995.

New standards for undernutrition
Wasting (weight for length <2 z scores) is a standard marker of acute malnutrition at a population level. Kerac’s provocative statistical analysis of the implications of the change from the older National Centre for Health Statistics (NCHS) to new WHO standards in the estimation of the prevalence of wasting is philosophically compelling. As screening tools, both identify under nutrition on a population scale and guide intervention but the WHO tool suggests a prevalence of wasting severe wasting 1.7 and 3.5 times greater in young infants than the NCHS, respectively. Neither method is inherently better and, with stretched resources, how would services respond to the greater WHO estimate? See page 1008.

Long-term ventilation
I recall early trials of overnight mask continuous positive airway pressure being conducted on adult muscular dystrophy patients in the late 1980s. Time has moved on and now almost 1000 children in the UK now receive partial or full time long-term ventilation and most paediatricians have at least some personal experience. Provision of packages of care including technical support, community nurse input, inhouse nursing care are now feasible. The commonest mode is the non-invasive mask and the largest single group those with neuromuscular disease accounting for 40%. Wallis’ census gives a flavour for the state of the art. Advances invariably generate difficult questions not just in health economic terms but in appropriate selection of the children whose lives will be substantially enhanced by the intervention and those whose life quality may not be. See page 998.

Parental responsibility
Woolley’s challenging piece on the evolution and legal nuances of parental responsibility demands to be read by every practising paediatrician. It illustrates the tensions between PR and child/adolescent autonomy and the 1989 Children’s Act on which many tenets are based now seems to belong to a more innocent era. See page 1060.

Adolescent safeguarding
The vast majority of child protection cases covered by the media involve preschool children. At the risk of generalising, the common perception is that adolescents are immune but the harsh reality is that almost a third of all serious case reviews involve 11 to 17 year olds. The clues are often more subtle, often a result of ‘belonging’ (and wanting to) a particular group and the subsequent susceptibility to unwitting exploitation. Khadr’s review pulls no punches. See page 991.
Highlights from this issue

Nick Brown

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