



CrossMark

Highlights from this issue

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UNRECOGNISED VISUAL IMPAIRMENT IN CHILDREN WITH SPECIAL EDUCATIONAL NEEDS

It is well known that there is a high prevalence of visual impairment in children in special schools and that correction will impact positively on learning. Woodhouse and colleagues report a survey of visual screening practices in Wales and the results of testing in schools where screening programmes were not in place. Screening was patchy (20/38 schools). Of the 173 children tested (five special schools with no screening in place, response to invitation, take up 31% although time limited study) 73/173 had never had an eye test. 17% had low vision by WHO criteria, six of whom had never previously had an eye test. Of the 172 tested for refractive errors 50% needed a first time (29/173) or updated prescription. Of the 46 children previously prescribed spectacles only 23 were wearing them on the day of the testing. More than half of the children (86/173) had some ocular abnormality that was either sight limiting or warranted action to prevent loss of sight. The authors rightly express concern regarding this dataset – patchy visual screening, undetected low vision, undetected refractive errors, failure to wear prescribed spectacles, high prevalence of ocular abnormalities in this vulnerable group of children with special educational needs. The need for urgent action is highlighted by the authors and in an accompanying editorial – Identifying visual difficulty in children with special educational needs: where should we look? *See page 500 and 491.*

DOES THE WHITE CELL COUNT PREDICT SERIOUS BACTERIAL INFECTION

The white blood cell count and absolute neutrophil count is frequently used in the initial evaluation of febrile children for serious bacterial infection, supported by national and international guidance. De and colleagues report a prospective study of febrile children (age <5 years) who attended paediatric emergency departments with fever and had a blood count (3893 children, 25% of attendees). 714 (18.3%) had serious bacterial infection – urinary tract infection, pneumonia, bacteraemia plus others for example osteomyelitis. White cell count greater than 15×10^9 had a sensitivity of 47% (95% confidence

interval 43% to 50%) and specificity 76% (95% confidence interval 74% to 77%), ie 50% of cases would be missed and 25% over treated if WCC with this cut off was used as the only criteria. An absolute neutrophil count threshold greater than $10 \times 10^9/L$ had a sensitivity of 41% (95% confidence intervals 38% to 45%), specificity 78% (95% confidence interval 76% to 79%). The authors conclude that white blood cell count and absolute neutrophil count are not sufficiently accurate ‘triage tests’ for febrile children with suspected serious bacterial infection. The authors discuss their findings in the context of published guidance. In an accompanying editorial Richardson and colleagues discuss the role of investigation in the management of feverish illness – the importance of careful clinical assessment, appropriate investigation and interpretation of test results in the context of the case being considered is rightly emphasised. *See page 493 and 489.*

AETIOLOGY AND MANAGEMENT OF MALNUTRITION IN HIV POSITIVE CHILDREN

Three million children worldwide are infected with HIV and without treatment mortality is high. Malnutrition is a common problem for infected children particularly in resource poor settings. Mortality from severe acute malnutrition (weight for height less than –3 standard deviation score, mid arm circumference less than 11.5 cm in age 6/12 to 5 years) is three times greater in HIV positive than HIV negative children. This may reflect the increased risk of co morbidities including tuberculosis, respiratory tract infection, gastroenteritis). Malnutrition is multifactorial including increased need for calories and micronutrients, diarrhoea (chronic infection/enteropathy) and potentially reduced supply (food insecurity). Many additional social factors are relevant including delayed presentation, poor access to healthcare and limited access to treatment. Rose and colleagues review the complex aetiology – medical and social, prevention and treatment strategies. Treatment is based on WHO guidelines for the management of malnutrition but impacted on also by the issues above all discussed in detail in the paper. *See page 546.*

WEIGHING CHILDREN

We all know that childhood overweight is a serious problem. The real challenge is how

best to impact. O’Shea and colleagues, in a short report, compare general practitioners insights on weighing children with the experience of parents and children being weighed. In a postal survey of 490 GP’s (80.2% response) less than 5% report always checking weight (27.8% often, 58.6% sometimes, 10% never) with negative parental response cited as a potential factor. In 457 weighed 14.7% were overweight and 10.9% obese. 96.6% of parents indicated that checking weight was helpful although 4.4% of parents and 1 in 4 obese children responded negatively to being weighed. Their findings are important – if obesity is a risk factor for disease then weighing should be an essential part of clinical assessment. If children are weighed and found to be obese then some will potentially react negatively. The real challenge for clinicians is then to react positively, engage and work with the child and family to manage the problem. *See page 543.*

THE AUTONOMIC NERVOUS SYSTEM – LOST AMONG THE TREES

Relevant and important the autonomic nervous system is discussed in a comprehensive review this month. It is a useful reminder of the basic physiology as an important regulator, adjuster and coordinator of body systems and prompt of just how relevant it is to the manifestations of so much of the pathology we commonly see. Symptoms (physical and psychological) can be profound and disabling. Many ‘functional’ symptoms reflect autonomic dysfunction. The article is an very interesting and relevant journey through many conditions with important information relevant to symptom assessment, aetiology, diagnostic categorisation and treatment. *See page 552.*

IN E&P THIS MONTH

There is a structured approach to the management of recurrent oral ulceration, a review of the NICE guideline antibiotics for the prevention of early onset neonatal infectious, how to use capillary refill time and a structured approach to the management of the child with recurrent croup. All focused and relevant to clinical practice.

- Finally we have increased the number of Podcasts (including highlights), visit <http://podcasts.bmj.com/journal-adc/>