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Highlights from this issue

Nick Brown , *Editor in Chief*

request for help from a senior. *See page 467*

Status epilepticus: choice of second line drug

A child/young adult arrives in PED in convulsive status epilepticus (CSE). She receives your departmental guideline benzodiazepine of choice, usually midazolam or lorazepam, but continues to fit. What next?

The last 3 years has seen a mushrooming of RCTs examining relative effects of levetiracetam (LVT) against phenytoin (Phe) and valproate the newer and older kids' on the block. The individual results have been tantalisingly equivocal—differences in either direction, none alone conclusive and few of sufficient size to, alone, alter one's own practice. Most of us (perhaps a little inflexibly) have taken a 'better the devil you know' (whichever that is) stance. Colin Powell and colleagues systematic review and meta-analysis take us a step closer to an answer using primary outcomes of time to seizure cessation and adverse events as main measures. The whole group analysis showed a small advantage in CSE to LVT, but after a sensitivity analysis in which a study strongly favouring LVT was removed, differences were minimal. Adverse events were fewer, but not significantly so. It feels as if choice will come down, in part, to pragmatism: LVT is easier to draw up, doesn't require a pump to infuse and is quicker. Is this sufficient or do we accept there may simply not be sufficient data to call this one? After all, life can't always be dichotomised. *See page 470*

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IN DEFERENCE TO THE EQUIVOCAL

A common (if not universal) human phenotype is the need for an answer—ideally a definitive, dichotomous one—a yes/no with no shades of grey. I don't take sides on this nor am I being deliberately Machiavellian—conclusive findings feel reassuring, but shouldn't one also celebrate 'negative' studies with equal gusto. Studies showing no discernable difference have arguably more public health effect than positives—protection from potential harm further down the line that the 'positive RCT' hasn't shown, economic investment in the (usually) more expensive new treatment to name but two. Whatever it says in the brochure, all that really matters is that the study has been done well and the results are generalisable. I rest my case.

COVID-19 AND AGE

I think we can reasonably assert that we 'know a bit more about this virus than we did a year ago'. However, there are many gaps, one of which is the only partly resolved issue of the relative susceptibility of children and adults. The review by Petra Zimmerman and Nigel Curtis take answers to these questions to a new level. I can't do this justice in a few lines, but the arguments for the vascular vulnerability in adults related to age and tobacco, immune function, interferon antibody prevalence, CMV seropositivity, T and B cell differences goes a long way to explaining the now quite familiar epidemiology—essential reading. *See page 429*

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PAEDIATRIC EMERGENCY MEDICINE

Abuse and radiology

Two linked studies by Kathryn Glenn and Helen Daley and colleagues examine adherence to guidance on CT brain imaging in infants with possible suspected physical abuse. The studies (both retrospective and based on routinely collected data) were concordant. Rates of detection of abnormal radiological signs with implications (clinical and legal) in the most susceptible group, young infants (0–6 months) those with head swelling, bruising or neurological signs, were high (84% and 53% respectively). The yield was much lower in older children with no risk signs. The advantages of CT are largely practical: available 24/7 in most hospitals, quick enough (minutes) to avoid sedation or anaesthesia; the disadvantages are well known—irradiation. Here, again the authors are generally agree: despite the low yield in older children that it might be reasonable to weigh up an immediate CT against an interval 'Sievert-free' MR 2–5 days later in older children without any signs. *See pages 461 and 456*

Preparation

In suspected paediatric sepsis, time to intervention linked to familiarity with the environment or priming (physical and collegiate) is a strong negative predictor of outcome. In theory, repetition of simulation should help but literature endorsing this is scarce. Ben McNaughten and colleagues randomised a group of medical students and nurses to priming or not before a series of mannikin based scenarios. Though the primed group participants did not feel they were helped by their training, they performed significantly better in the key indices: time to IV access, administration of antibiotics and