

Highlights from this issue

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Confronting my own ignorance

I was a second year paediatric trainee working in our walk-in clinic when I was asked to see a 3-year-old boy from Africa with a rash. After a quick examination, I met with my supervising resident to discuss the case and told him that I was sure the patient had been abused. There were six to eight round ecchymotic bruises on his back. The parents did not speak English and could provide no good explanation for the bruises. The family was reported to social services. One week later I was informed that the patient had been subject to 'cupping', a type of health remedy.

There have been a number of recent reports that detail the impact of race and type of hospital on the reporting of children suspected of being abused.^{1,2} These are disturbing variations, since many professional societies have produced evidence-based recommendations that certain injuries are consistent with abuse and that clinicians should report children with such injuries to the appropriate authorities. Variation in reporting clearly reflects how individuals – for whatever reason – interpret these recommendations.

Variation in reporting of child abuse highlights the potential importance of a paper in this month's Journal. Smeekens *et al* from The Netherlands, describe the results of a randomised clinical trial in which paediatric nurses participated in a 2 h e-learning programme about the recognition of child abuse. The results are encouraging, the nurses in the intervention group were significantly better than those in the control group in detecting child abuse during simulation.

The term cultural competency did not exist in the 1980s. It became popular in just the last decade. At my institution we care for patients from close to 50 countries. Competency in every culture is simply not possible, but rather cultural awareness, or at least a core set of values when approaching a patient may be possible. Clearly I lacked cultural awareness as a young trainee in 1980. *See page 330.*

DHA for NAFLD non-alcoholic fatty liver disease

The obesity epidemic has given rise to two 'new' paediatric disorders – non-alcoholic

fatty liver disease (NAFLD) and metabolic disease. There is virtual universal agreement that lifestyle change accompanied by weight loss is the first treatment for both conditions. However, obese adolescents, just like obese adults, struggle to maintain substantial weight loss. In a randomised double-blind controlled trial from Italy, Nobili reports that dietary supplement with docosahexaenoic acid (DHA) in 60 children (mean body mass index ~26) with biopsy proven NAFLD improves liver steatosis and insulin sensitivity. We don't yet know if the long-term benefits of DHA exceed the risks. *See page 350.*

Yet another attempt to identify SBI in infants

I have written many times about the attempt over 40 years to identify infants and children with serious bacterial infection (SBI). Initially we used just a complete blood count, blood culture and an LP when indicated to help identify these children. This was followed in the early 1980s by the development of the Yale Observational Scale, an observational approach to the evaluation of the febrile infant. Then we returned to a laboratory-based approach with the debut of the Rochester, Philadelphia, and Boston criteria. By this time testing had expanded and included a urinalysis and when indicated a urine culture. Both the behavioural and laboratory approaches were developed before the introduction of the conjugate pneumococcal and *Haemophilus influenzae* type B vaccines. These two vaccines have reduced the incidence of SBI dramatically, impacting on the positive and negative predictive value of any approach. Now Andrew Brent and colleagues have developed yet another new risk score that relies on some historical items and vital signs. They found that their score could identify most children with SBI. However, is a positive predictive value of 80% or 90% good enough if the SBI is bacterial meningitis – would any clinician risk missing even 1 child in 100? I have never completely adhered to any of these approaches, however, they are superb teaching tools, and help inform the decisions I make when seeing young febrile infants and children. *See page 361.*

A provocative pilot study

Some data suggest that probiotics may improve humoral and cellular response. In a pilot RCT from Israel, 47 infants received either daily probiotics or placebo for a total of 5 months, beginning 2 months before immunisation with measles mumps rubella vaccine. Although no differences emerged to the individual components of MMRV, less subjects in the probiotic group failed to reach protective IgG antibodies to all of the antigens in the vaccine (probiotic group 8% vs placebo group 17%, $p < 0.052$). These results, if duplicated in a larger study, would have important implications in areas where completion of the primary series of immunisations is difficult. *See page 345.*

More big heads in the UK

In 2009 the UK-WHO head circumference charts were introduced. Charlotte Wright *et al*, report that a substantially greater percentage of infants – 6–16% versus 1–4% – will plot out greater than the 98th percentile based upon these charts. Conversely substantially less will graph out less than the second percentile. They highlight that single measures are not nearly as important as the pattern of head circumference growth, but that crossing major percentiles in a short period of time early in life should raise the concern of hydrocephalus. I have seen a number of infants who in the first 6–9 months of life move quickly over two to three major percentiles. If an infant has a normal neurologic examination and his or her weight has increased proportionally, I often just observe the child. If the rapid head circumference growth is an isolated finding, or the neurologic exam is abnormal then I request a head ultrasound. In older children with large heads I always start by asking the parent one question – what is your hat size, even though they rarely know – inevitably I hear "Oh, I have a very large head." *See page 386.*

References

1. Lane WG, Rubin DM, Monteith R, *et al*. Racial differences in the evaluation of pediatric fractures for physical abuse. *JAMA* 2002; **288**:1603–9.
2. Trokel M, Waddimba A, Wadimmba A, *et al*. Variation in the diagnosis of child abuse in severely injured infants. *Pediatrics* 2006; **117**:722–8.