



CrossMark

Highlights from this issue

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The most consistent finding was an association between napping and later onset, shorter duration and poorer quality night sleep with evidence strongest in children greater than 2 years. The authors highlight the absolute need for more data before specific advice is given. Lucy Wiggs discusses the findings and their wider implications in an accompanying editorial. It is interesting to reflect on what is normal—how should a nap be identified (quantity, quality, timing), heterogeneity of the individual, influence of the family and environment, and multiple potential outcome measures of impact and therefore difficulty in studying. Certainly napping in young children is universal and the question posed in the title of the editorial—Daytime napping in preschool aged children; is it to be encouraged—is appropriate. Ensuring children receive sufficient amounts of good quality sleep, according to their individual needs, remains the priority. *See pages 615 and 604.*

WHY DO WE TREAT CHILDREN OF JEHOVAH'S WITNESSES DIFFERENTLY FROM THEIR ADULT PARENTS

This is a significant, emotive and difficult issue particularly when the clinician is faced with a patient who needs a blood transfusion but refuses it for religious or other reasons. In a thought provoking leading article Robert Wheeler explores these issues, using case law to illustrate and very much highlighting the different issues in children compared to adult and as such is very relevant to us as paediatricians. The decision of a competent adult to refuse blood is legally binding on doctors. This is not the case in a child or young person under age 18 years when the law will no longer defer to a parent's wishes or religious beliefs if such deference will mean that the child is not treated in accordance with his best interests. This clearly needs to be managed carefully and with consideration of alternative options and after social care and legal advice. The issues and some of the practicalities are complex, even more so during adolescence and the article of relevance to how we manage these difficult situations when blood transfusion or other life saving treatment are needed and for complex reasons consent not forthcoming. *See page 606.*

TOO MANY DIGITS—THE PRESENTATION OF NUMERICAL DATA

We have all been frustrated reading numbers to too many decimal places, the simplest being digital scales in the outpatient clinic where measurements are probably not accurate to more than 10g although the implication of the weight recorded is that the accuracy is much greater. In an excellent leading article this month Tim Cole takes us back to first principles to discuss this and provide sensible, pragmatic guidelines for the presentation of numerical data. It is interesting and helpful to work through. Remember the difference between decimal places and significant figures. The number of significant figures (digits) is the number of all digits ignoring the decimal point, and ignoring all leading and some trailing zeros. Data should be rounded appropriately—not too much, not too little. Clearly, for example 22.68 (95% confidence interval 7.51–73.67) is more effectively and meaningfully written as 23 (95% confidence interval 7.5–74). The various reporting tools are discussed. Significant figures should be considered rather than just decimal places. The general principle is to use two or three significant digits for effect sizes, and one or two significant digits for measures of variability. There is a helpful summary table included with recommendations given for different scenarios. *See page 608.*

PREVALENCE OF SEVERE CHILDHOOD OBESITY IN ENGLAND

Severe childhood obesity is associated with a wide array of serious immediate and long term health problems and may require specialist input for consequent medical issues and weight management. Ells and colleagues review the rates of severe obesity (BMI > 99.6th centile of the British UK90 charts). Rates are very high—1.9% of girls and 2.3% of boys aged 4–5 years, 2.9% of girls and 3.9% of boys age 10–11 years. Prevalence is variable being highest in children living in the most deprived areas (2 to 3 times greater) and in black ethnic groups. Support and provision for this group need to be planned if we are going to impact to try to reduce morbid obesity rates and their long term impact at an individual and population level. *See page 631.*

BED SHARING AND SUDDEN INFANT DEATH

Bed sharing increases the risk of sudden infant death in infants less than 3 months. The effect is most profound in infants less than 1 month (5 fold increase in risk of SIDS in infants less than 1 month). The mechanism is not clearly defined. Heyman and colleagues review the accidental deaths during sleep (as a cause of sudden infant death in infancy); New Zealand 48 cases, 2002–2009, 0.1 per 1000 live births. Deaths were due to overlay (n=30), or wedging (n=18), with 34 (71%) in a bed sharing situation. Of the overlay group 8 were by a mother while breast feeding, 4 by a sibling and 17 by a parent. In the wedging group 10 were between a sleeping surface and wall or broken cot, 6 between a cushion and couch and 2 between a sleep surface and bedding. The authors conclude these are potentially preventable deaths particularly if bed sharing is avoided, faulty or if inadequately constructed cots are avoided and extra attention is paid to the safety of sleep arrangements particularly if adhoc/temporary. In an accompanying editorial Volpe and colleagues discuss—Infant sleep related deaths: why do parents take risks. The editorial is provocative discussing these issues in the context of other factors, recent guidance from NICE and the need to inform parents about the risks and benefits in order to help them make the best decision for them and their child. *See pages 610 and 603.*

SHOULD WE DISCOURAGE DAYTIME NAPPING

Duration and quality of sleep affect child development and health with early childhood being a time in which sleep consolidates into the night and napping ceases. Many factors influence sleep patterns and childhood sleep patterns have the potential to disrupt family functioning and child well being. Thorpe and colleagues report a systematic review of the evidence regarding the effects of napping on child development and health. 26 articles were included—heterogeneous quality, observational study designs. Most of the findings were inconsistent—cognition, behaviour, health impact—probably because of variability in ages and habitual napping status.