Highlights from this issue

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FEMALE GENITAL MUTILATION

125 million women and girls worldwide have had female genital mutilation (FGM). There is no robust UK data although it is estimated that over a 137 000 adult women and a further 70 000 girls under the age of 15 years have either had or are at risk of FGM. FGM has been illegal in the UK since 1985 and in 2013 it became illegal to take a child abroad for FGM. Mandatory reporting for regulated health and social care professionals and teachers came into effect in England and Wales this year. Hodes and colleagues report their experience of children referred with suspected FGM to a UK safeguarding clinic (47 children, 2006–14). 27 had confirmed FGM—type 1 in 2 (most severe), type 2 in 8, type 4 (pricking and nicking) in 11. The circumstances of the FGM were known in 17, 12 being performed by a health professional or in a medical setting. Eight out of 27 had one or more medical symptoms including pain, bleeding, tenderness, dysuria, nocturnal enuresis, adhesions. 17 had had the FGM performed outside the country either before they moved here (14) or being taken out before 2003 when it became illegal. In 10 cases this was less clear and although police and social services were involved there were no successful prosecutions. This data represents an important snapshot of FGM in the UK. There is now a British Paediatric Surveillance Study in process. In an accompanying review Sarah Creighton and Deborah Hodes discuss FGM : What every paediatrician needs to know. Goeff DeBelle reflects on the two papers with a leading article Female Genital Mutilation: making the case for good practice. ***See pages 212, 267 and 207***

THE LEGAL BASIS FOR COMPULSORILY DETAINING CHILDREN AND YOUNG PEOPLE FOR TREATMENT

This is a complicated area and clinicians can usually cite cases from their experience when there has been significant difficulty. Robert Wheeler and Anthony Crabb discuss the specific issues for three different age groups—adults, young people (16–17), children age 15 and below and the position for children: parental consent for deprivation. The article is helpful and up to date and cites specific case law. In essence the important issues to understand are when and for what the Mental Health Act can be used, the role of the Mental Capacity Act, the role of the Children Act, the role of decision making by young people and rights and responsibilities of parents who are major 'stakeholders' in decision making in young people less than 18 years of age. In difficult situations advice and input from the multidisciplinary team including legal and social care is essential to achieve the best outcome for the young person, their family and the professionals involved. ***See page 210***

FAMILIES PRIORITIES IN LIFE LIMITING ILLNESS

Improving quality of life is the central focus of palliative care support for children with life limiting illness although achieving it can be challenging and monitoring is even more difficult. Harris and colleagues report their experience with MyQuality (32 families of children with life limiting conditions, three hospices). MyQuality is a generic online tool that enables families to choose and monitor parameters they identify as having an impact on their quality of life and thereby aims to improve patient professional communications and enhance patient empowerment within healthcare dialogues. 23 out of 32 families chose to use the website, most choosing to monitor two to three parameters most commonly seizures (24), constipation (9), pain (6), sleep problems (6). Family empowerment scores increased during the 3 months studied. Interview feedback confirmed the acceptability and ease of use of the website, and the value of a graphic record of change over time to support ongoing management and collaborative review of medical, nursing or social interventions. The process of generating priorities and monitoring change over time is empowering for patients and their families and informative for staff. The tool has the potential to improve the quality of life and care of children with life limiting and other chronic conditions. More research is needed. ***See page 247***

COELIAC SCREENING IN TYPE 1 DIABETES

Children with type 1 diabetes are at increased risk of coeliac disease. Recent guidance suggests that screening should include HLA typing for DQ2/DQ8 genotypes and those negative for these alleles require no further coeliac screening. This is based on the fact that less than 1% of patients with CD are HLA DQ2/DQ8 negative although 30% of the general population will have one of the coeliac-associated haplotypes, possibly higher in type one diabetes (Dutch cohort 86%). This has resulted in the role of HLA typing in screening children with diabetes for coeliac disease being questioned. Mitchell and colleagues report their experience across two large cohorts of children with type 1 diabetes in Scotland (n=176). DQ2/DQ8 alleles were identified in 94% of patients. All patients with coeliac disease (11/176) were positive for HLA DQ2/DQ8. All were diagnosed within five years of the diagnosis of type 1 diabetes. The authors rightly conclude that if most children with diabetes are HLA DQ2/DQ8 positive then it is not particularly helpful (or cost effective) as part of the screen for coeliac disease although clearly a negative test does suggest a low/minimal risk. ***See page 230***

MANAGEMENT OF SPEECH AND LANGUAGE DISORDERS

These are common problems and the identification of developmental problems in a child's acquisition of speech, language and/or communication is a core activity in child surveillance; 15% of toddlers are 'late talkers' and 7% of children enter school with persisting impairments of their language development. Early assessment and management (including the assessment of hearing) is a key priority in order to prevent the potential negative secondary impact. In this issue there are two excellent reviews by Anne O'Hare and Lynne Bremner who explore key issues including normal language development, specific language problems, assessment, investigation and management including discussion of acquired disorders. It is important to establish whether disorders are primary or secondary (for example cerebral palsy, learning difficulties, syndromal). It is important consider both speech and receptive language. It is important to consider 'regression of communication' as a feature of autism and early features are discussed. Further investigation should be informed by clinical assessment and can improve prognostication. Treatment should be evidence based —there is a review of the different treatment options. The second paper deals with the acquired conditions—including traumatic, neurodegenerative, tumour and seizure related. Both papers are essential reading for clinicians who see children many of whom may have issues with speech and language and benefit from specialist input. ***See pages 272 and 278***