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Highlights from this issue

R Mark Beattie, *Editor in Chief*

PREVENTION OF NEURAL TUBE DEFECTS IN THE UK: A MISSED OPPORTUNITY

In 1991 the Medical Research Council (MRC) demonstrated that folic acid taken before pregnancy and in early pregnancy reduced the risk of a neural tube defect (NTD). The concern is that most women do not take folic acid supplements (40% 1999, 27% 2012—England). Morris *et al* report an estimate of the number of NTD pregnancies that would have been prevented if flour had been fortified with folic acid from 1998 (as it was in the USA). Data is from congenital abnormality registers in England and Wales. The estimate for reduced risk is 27%. Based on this data the authors estimate that 2014 fewer NTD pregnancies would have occurred. The authors rightly highlight that the failure to implement folic acid fortification of flour in the UK has caused, and continues to cause, avoidable terminations of pregnancy, stillbirths, neonatal deaths and permanent serious disability in surviving children. There is an interesting accompanying editorial—Fortification of flour with folic acid is an overdue public health measure in the UK, in which other missed opportunities including the delays in limitation of smoking in public places, the slow implementation of preventative measures for venous thromboembolism in hospitals and the failure to extend the implementation of fluoridation of water are highlighted. *See pages 604 and 593.*

OUTBREAK OF ZIKA VIRUS IN BRAZIL (AND BEYOND): IMPLICATIONS FOR PAEDIATRICIANS

Zika virus (ZIKV) was previously considered to be an arbovirus of limited importance. We are all aware now of the large, ongoing outbreak that started in Brazil in early 2015 and is spreading rapidly across the Americas and has been potentially linked to congenital abnormalities (including microcephaly) and Guillan Barre Syndrome. Ladhani *et al* review the virology, epidemiology, clinical manifestations and implications for paediatricians. The virus generally causes a mild self-limiting illness. The main vector for transmission is the mosquito although the

virus has been detected in semen and blood making sexual transmission a possibility. In Brazil there has been an unprecedented increase in infants presenting with microcephaly (>4000 notifications compared with the expected 150–200 annual cases) temporally associated with the increase in ZIKV. The association, although not proven, is felt to be likely. There has also been an increase in cases of Guillan Barre Syndrome. The spread of ZIKV is likely to continue and cases have been reported in Europe. There is no treatment or vaccine available. This has implications for travellers, particularly if pregnant or looking to get pregnant. Paediatricians and neonatologist need to be aware of the outbreak and potential for further spread recognising that most infections are asymptomatic or mild and self limiting. ZIKV should be considered in the differential diagnosis in any child returning from a ZIKV endemic area with fever, acute neurological presentations in patients returning from a ZIKV endemic area and considered as part of the work up of miscarriage, stillbirth and congenital infection and infants presenting with congenital abnormalities, particularly microcephaly. *See page 600.*

HEALTH OF ADOLESCENT REFUGEES RESETTLING IN HIGH-INCOME COUNTRIES

This is a timely and helpful review. Despite a constantly growing number of adolescent refugees resettling in high income countries knowledge regarding their specific health care needs is limited. Physical health problems are common—particularly infection, nutritional deficiencies and chronic disease. There are often multiple stressors—family, social, cultural and educational and they are at a heightened risk of developing mental health problems. These issues need to be addressed systematically, carefully and sensitively and can be complicated by legal and ethical issues. Early identification and management of the healthcare issues are key to improving long term health outcomes and the future healthcare burden. In this excellent review the authors review the issues and offer practical guidance including case vignettes which help focus

the reader. Issues like sexually transmitted diseases, reproductive health, adolescent pregnancy and child marriage are important to consider. There is a useful section on psychological health. Socioeconomic factors are very relevant to outcome—the adolescent will likely be challenged by a new language and new culture, and this ‘acculturation’ (the process of adopting the cultural traits or social patterns of another group) can be quite challenging for the individual and their families. Health needs to work closely with education. There are many risk factors for child maltreatment and child protection agencies will have a role in specific cases although the issues may not necessarily be straightforward. The authors suggest a framework for health professionals for the assessment and management. This is a very relevant article and although somewhat sobering to read should be essential reading for clinicians involved in looking after these potentially very vulnerable young people. *See page 670.*

IS SCREENING FOR URINE INFECTION IN WELL INFANTS WITH PROLONGED JAUNDICE REQUIRED?

The National Institute for Clinical Excellence (NICE) neonatal jaundice guideline recommends a urine culture for infants who present with prolonged jaundice. Steadman *et al* review their own experience (279 infants, 3 years). None met the clinical criteria for UTI. 145 had a negative urine culture, 114 mixed growth, 20 a pure growth—5 with a pure growth >100,000 cfu/ml (= the NICE diagnostic cut off) which on repeat were lesser or no growth, ie, no child had a confirmed urinary tract infection (by NICE criteria). This is in keeping with other published UK data—0.4% (0–0.8%), mostly reflecting coincidentally identified asymptomatic bacteriuria. The authors advise that the need for urine culture should be reconsidered when assessing well children with prolonged jaundice. Of some interest some of the non UK data reports a higher incidence (see table 1, figure 3) although many use different diagnostic criteria and collection regimes. *See page 614.*