



CrossMark

Highlights from this issue

Martin Ward Platt

UNINTENDED CONSEQUENCES OF IMMUNISATION

Readers of *The Lancet* may have noticed that an unlooked-for benefit of the introduction of the new immunisation against group B meningococcal disease is partial but significant protection against gonorrhoea (DOI: 10.1016/S0140-6736(17)31449-6), identified in New Zealand. Closer to home though, there are less benign issues with Bexsero: the consequences of the febrile response to the vaccine are such that we have three related papers and an accompanying Editorial. Nainani *et al*, with data from Oxford, and Kapur *et al* from Belfast, have analysed the impact on their respective emergency departments, while Murdoch *et al* have looked at hospital admissions in Scotland. In a nutshell, a proportion of infants immunised with Bexsero became sufficiently feverish and unwell that they pitched up to emergency departments in the days following the injection. Some ended up admitted and given antibiotics just in case they had a bacterial infection; indeed many of these infants are over the bar in relation to the current NICE guidance 'Fever in under 5s: assessment and initial management' (CG160). So in exchange for the lives saved (and later the gonorrhoea prevented) there is some short term increased 'unnecessary' medical work, inconvenience for families, exposure to potential harm for infants, and an unmeasured impact on the overall cost-effectiveness of the new immunisation. Shamez Ladhani puts all this in context in his Editorial. *See pages 958, 899, 894 and 881*

ILLNESS AND RISK OF DROWNING

Even as I write, there is fresh news of a 4 year old child drowning in a swimming pool while on holiday in Devon. This is probably the situation that most springs to mind when we link the words 'child' and 'drown', but there are no fewer than 14 other recognised scenarios of drowning. According to publicly available data from the Office for National Statistics, in England and Wales in 2016 there were just 15 deaths by drowning in children aged

0–14. The problem is bigger in Australia: Franklin *et al* analysed 468 child drownings in children aged 0–14 over 10 years. Their purpose was to investigate drowning in relation to illnesses that might plausibly have contributed to the children's deaths, and they found that only epilepsy was a significant risk factor. Richard Appleton picks up the issue of epilepsy and water safety in greater detail in the accompanying Editorial. *See page 888 and 883*

MANAGING CFS/ME

In ADC we have carried several papers about chronic fatigue syndrome over recent years, and it is clear that our understanding of the condition has greatly increased. Online, though not yet in print, we have a report of a good quality randomised controlled trial of the Lightning Process as part of CFS therapy, showing that it works. In this print edition Brigden *et al*, writing from the Bristol-Bath group of therapists and researchers, give us a review that pulls current knowledge and their own experience together into a practical guide for the management of CFS. As the condition has an undeserved reputation for being 'difficult' to deal with, I hope this piece will be widely read and dispel some of the myths that surround it. Above all I hope that it will prove a valuable resource for trainees. *See page 981*

SYSTEMATIC REVIEW OF YOUTUBE

I hoped this oxymoron of a subtitle would catch your eye. What Knight *et al* actually asked was: Are parent-uploaded videos of their unwell children a useful source of medical information for other parents? This is an important question, though it is a bit value-laden with regard to what might be viewed as 'useful'. From a professional point of view, 'useful' often means 'accurate', but Knight *et al* also focused on the quality of the videos posted. They found that very few examples of either croup or dehydration were

both clinically accurate and of acceptable technical quality. YouTube can be an important resource for parents and children, so the idea of professionally curated clips relating to those medical conditions that are amenable to video explication is attractive, but so far little has been done to develop such a resource. Might this be a role for the College, for specialty groups, or for one or more of the children's hospitals? Go online, use the Responses tab to the left of the Atoms content, and tell us what you think. *See page 910*

THE RATIONALE FOR SPECIALIST PALLIATIVE CARE

There is general recognition that with more children surviving serious illnesses but left living with life-limiting conditions, there is a need for paediatric palliative care services to be developed as a specialty. As Mitchell *et al* acknowledge, developments for children, as for adults before them, have largely been driven by motivated individuals in the voluntary sector resulting in the development of children's hospices, and terminal care for cancer has often been the starting point. But what are the measurable benefits of such services and such care? Policy making has largely been reactive to service developments and has occurred in a vacuum of information. This systematic review attempts to address the information gap, but concludes that good, rigorous research is thin on the ground. Despite its paucity and methodological limitations, the evidence tends to favour the notion that specialist palliative care services can improve the quality of life for children and their families and help with symptom control. It is also possible that they increase the chance of the death taking place in a preferred place. When resources are stretched, evidence is at a premium, so let us hope this work will stimulate bigger, better and more rigorous studies to quantify the benefits and demonstrate the need for the resources. We don't want an information gap to lead to a commissioning gap. *See page 923*