Highlights from this issue

R Mark Beattie, *Editor in Chief*

IMPACT OF ENVIRONMENTAL TOBACCO SMOKE EXPOSURE ON ANAESTHETIC AND SURGICAL OUTCOMES IN CHILDREN

Environmental tobacco smoke (ETS) has been shown to have a significant impact on the health of children and young people. This includes an increased incidence of respiratory infection, asthma, ear infections and meningitis. Children are more vulnerable than adults. Chiswell and colleagues report a systematic review of the impact on anaesthetic and surgical outcomes. 28 relevant studies were selected (15 anaesthetic, 12 surgical, 1 secondary outcome). The pooled data was sufficiently robust to demonstrate that ETS exposure significantly increased the risk of peri-anaesthetic respiratory events (pooled risk ratio 2.52, 95% confidence interval 1.68–3.77). This has important implications for child and family and should be discussed as part of the preoperative work up. In an excellent accompanying editorial Pugmire and colleagues discuss the wider issues of the impact of environmental tobacco exposure throughout the life course including a 'call for action' with practical proposals—Environmental tobacco smoke exposure among infants, children and young people: now is no time to relax. ***See pages 123 and 117***.

OUTCOME OF INFANTS BORN NEAR TERM

Most research on outcomes focuses on infants born at <32 weeks gestation. Gill and colleagues review the outcome data on infants born late preterm (34–36 weeks) where epidemiological studies have demonstrated increased risks of mortality and adverse neonatal outcomes. The authors include recent studies which have also included data on infants born 'early term' (37–38 weeks) where excess mortality and morbidity is seen. It is a very interesting paper to work through and should encourage us to think about 'late preterms' as a continuum in which risk and severity of adverse outcomes increase with decreasing gestational age and measurable effects can be detected even in infants born very close to term. The traditional definition of term being greater than 37 weeks gestation should probably be challenged. ***See page 194***.

NON-ACCIDENTAL SALT POISONING

Deliberate salt poisoning is a serious cause of hypernatraemia in children and represents a diagnostic challenge for the treating physician. Wallace and colleagues review the key features. It is rare but should be considered if there is hypernatraemia without evidence of severe dehydration. Patients at highest risk are those without access to free water. Diarrhoea and vomiting do not exclude the diagnosis. It is useful to calculate the free water deficit (the minimal expected weight loss in hypernatraemic dehydration) and compare it with observed weight loss. Fractional excretion of sodium is a key investigation (usually <1%). The authors discuss how to calculate and how to interpret in the article. Once salt poisoning is suspected then a forensic approach needs to be taken to further investigation. Measurement of the sodium content in the gastric aspirate should be considered. The authors give two case scenarios which are helpful. ***See page 119***.

ON A PERSONAL NOTE

This is my last edition. I have worked for the journal for 10 years, the last 5 as Editor in Chief. It has been an honour and a privilege. As Editor in Chief I have handled more than 10,000 articles, overseen the production of 120 editions, chaired more than 100 editorial meetings and written (and podcasted) highlights every month. It has been a very exciting time. Editors have many challenges including selecting the best articles from the many submitted to commissioning the best content for readers. This needs to be readable, relevant and focused and enable clinicians to make better decisions. I hope very much that we have achieved this. If we have then it is a tribute the fantastic team of editors from the UK and overseas who have worked so hard and with such energy and commitment to enable this to happen.

I have spent a great deal of time reflecting on the journal's mission—and adapting it to the 21st century. This includes the need to make sure the journal is relevant to anyone who looks after children and young people—not just the doctors. It includes the need to embrace the social media opportunities to project evidence-based medicine in an era when we are all challenged by the amount of material available to read. We want papers to be read and influential. Keeping the message focussed is crucial; to paraphrase Albert Einstein—if you can't say it simply, then you don't understand it well enough…

In the first edition of this journal, in 1926, Sir Thomas Barlow wrote these wise words…

'The reasons for the publication were that conclusions scattered through various publications should be available, there should be opportunities for research to be published and criticised and adoption of research into practice should be promoted.'

Ninety years on we are still challenged by how to best get evidence into clinical practice.

I am pleased to leave the journal in a healthy state with increasing submissions, impact factor, downloads and international reach. I am forever indebted to the authors, reviewers, editors, publishers and readers who all contribute to the success of the journal and for the honour and privilege of having been the Editor in Chief of the *Archives of Disease in Childhood* journal suite.