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# Highlights from this issue

Martin Ward Platt

## 'HELP' DOES NOT HELP

You may have spotted this comment on the front cover. The paper by Christie *et al* reports that The Healthy Eating and Lifestyle Programme was no better than a single educational session for reducing obesity among adolescents. HELP joins the ever lengthening list of plausible approaches to obesity that have a good theoretical basis but when rigorously tested, fail to work. The accompanying Editorial tries to be upbeat, but you sense the struggle. The only good thing to emerge from this litany of failure is that it will help to avoid wasting far more money than the studies cost by avoiding the implementation of costly interventions that don't work. At a time of severe resource constraint, this is really important. *See pages 689 and 695.*

## GROWING UP, CATCHING UP

There is a widespread belief, backed up by some older studies, that babies born much smaller than they should be remain small throughout childhood, even if they show some catch-up weight gain in the first few postnatal months. Beukers *et al* distinguished between babies who were merely small but normal (for genetic/familial reasons) and those for whom there was good evidence that they suffered from fetal growth restriction. They demonstrated that growth-restricted babies continue to catch up throughout childhood, so that by 13 years old they had achieved parity with their peers in terms of weight, height and head circumference. *See page 735.*

## HIRSCHSPRUNG'S: THE REALITY

Not all paediatricians know that the Association of Paediatric Surgeons has a surveillance system similar to the British Paediatric Surveillance Unit. Bradnock *et al* report the principal findings of their 2 year surveillance of Hirschsprung's disease. They identified 305 cases presenting before the age of 6 months, giving a birth prevalence for the UK and Ireland of 1.8 per 10000 live births. Perhaps most importantly as a practice point, the timing of the passage of meconium was

shown to be almost completely useless as a clue to the condition. A third of all cases were discharged home after birth, only to present later, mostly in the first month; and just a tenth presented later than 28 days. A third ended up with a stoma ahead of definitive surgery. This is new, definitive, helpful and of direct practical relevance to paediatricians and surgeons alike. *See page 722.*

## BPSU

We also have a paper from the BPSU itself. Pseudotumour cerebri syndrome (PTCS) is a niche subject and a rare condition, which I always knew as benign (or idiopathic) intracranial hypertension though that is clearly not the PC term anymore. In contrast to Hirschsprung's disease (previous highlight), Matthews *et al* found only half as many cases of PTCS over 2 years: 185 by classical criteria but just 166 if you take only those fulfilling current revised criteria, giving an annual national incidence rate of 0.71 per 100 000 in the 1 to 16 year age group. Nine out of 10 cases were aged 7 to 16. PTCS was found to be strongly associated with female sex and obesity, and is yet another disease for which effective management includes weight loss. *See page 715.*

## MICROCEPHALY

Identifying cases of microcephaly and severe microcephaly is a good way of assessing the impact of Zika virus infection in an at-risk population, even though the spectrum of harm from Zika goes well beyond microcephaly itself. However it is only of value when background rates of microcephaly are known accurately, and this has been a major limitation of studies that focused on head size only when the impact of Zika was becoming apparent. Magalhães-Barbosa *et al* have sought to rectify this gap in our knowledge by reporting the rates of microcephaly from eight private neonatal services in south-eastern and midwestern Brazil from 2011 to 2015. Their data show that although there was the expected year-on-year variation, rates over the 4 years 2011 to 2015

were relatively stable. Although these data were those from a particular population at a particular time, the rates will be of interest to other countries where Zika may yet become a more serious problem. *See page 728.*

## PAEDIATRIC PREVENTIVE CARE

When 42 clinicians and 115 parents came up with their top 10 priorities for paediatric preventive care research, Lavigne *et al* report that the one that came out top of the tops was 'What are effective strategies for screening and prevention of mental health problems?' I think we can all agree on that. The topical 'What are effective interventions for obesity prevention in young children?' came fourth, and 'How much screen time is appropriate for children?' came tenth. This list was from Canada so we don't know whether the same would have been true here, but maybe this paper will stimulate the Royal College of Paediatrics and Child Health to do some similar work in the UK. The paper should link in readers' minds to Archivist on 'Bedroom TVs and obesity' which neatly pulls together two of the research issues identified. *See pages 695 and 706.*

## THE NUTS AND BOLTS OF STUDIES

This edition is strong on research related themes. I'll first draw your attention to Winch *et al*, reporting data from surveys done by the Royal College of Paediatrics and Child Health on research participation by UK consultants. They document a real and concerning decline but can only speculate on the underlying causes for it. Perhaps giving a glimpse of one cause, Roberts *et al* in a letter highlight some classic bureaucratic barriers to a very simple piece of research: most people faced with these problems would have lost the will to live, never mind the will to do research. Finally, Lythgoe *et al* in a review paper explain what the NIHR clinical networks are, and how they can help research, so at least we end on a positive note. *See pages 702, 755 and 786.*