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Highlights from this issue

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NEW EDITOR IN CHIEF

It gives me great pleasure to announce that our new Editor in Chief is Dr Nick Brown. He will assume the role on 1st October; this will enable me to stand down from my interim position, but because of the lag between finalising copy and publishing each edition, you will see my name on Atoms until Nick's appears in the December issue. Readers will remember that Nick has been with *ADC* for some years. His day job is as a general paediatrician in Salisbury, and his strong international links have enabled him to look after our Global Child Health section. He will bring both continuity and renewal to the Journal and I know that I speak for all my Associate Editor colleagues in wishing him well for his tenure.

GROWTH IN CHILDREN BORN WITH OESOPHAGEAL ATRESIA

In *Fetal & Neonatal* this month we have a paper by Vergouwe *et al* from The Netherlands which addresses growth to 12 years old in children born with oesophageal atresia. Those who do not normally read *F&N* might like to take a look: after excluding those with associated conditions known to impact on growth, a fifth were small for gestational age and a quarter had other associated anomalies, but the trend was to catch up and achieve comparable weight and height status by 12 years old. Growth was not so good in the 23% of the children who got a fundoplication, though one presumes that poor growth was one of the indications for the operation in the first place. There may be a case for more aggressive nutritional support for these children in their early years, but this needs to be tested in a randomised trial. *See page F417.*

MICTURATING CYSTOURETHROGRAMS

Can we safely do fewer MCUGs in infants under 3 months with a first urinary tract infection? Pauchard *et al* argue that we can. In the accompanying Editorial, Peter Hoyer is cautious. These observational data, in 122 children under 3 months old at the

time of their first uncomplicated urinary tract infection, suggest that if the causative organism is *E. coli*, and a renal ultrasound is normal, then the chances of missing significant urinary reflux could be less than 1%. If true, this would make it difficult to justify undertaking invasive investigations in these young infants. The debate about the best management of infants with urinary tract infection rages on with little more light, and no less heat, than 30 years ago. *See pages 805 and 791.*

BLINDNESS

Children with visual impairment often have other problems that require some degree of paediatric supervision, so it is incumbent on the paediatric community to know a bit about it. Globally, though, the picture is very different to that in the clinics of resource rich countries: the paper by Solebo *et al* points out that retinopathy of prematurity, cataract and corneal opacity are the prime causes worldwide. Tragically these are largely preventable, and ironically the problem of retinopathy of prematurity is the history of rich countries in the 1950s repeating itself in the emerging economies of the 21st century. In truth many of these 'eye' diseases are the ophthalmological manifestations of fundamentally paediatric and public health problems: perinatal care, congenital rubella, and lack of vitamin A. *See page 854.*

A IS FOR AIRWAY

But the Airway in ABC is not always just about positioning, jaw thrust, mask ventilation and maybe intubation. A small but important proportion of children presenting to emergency departments have challenging airways that need extra facilities and equipment, and the magnitude of this problem is explored by Simma *et al*, from Melbourne, Australia. In their big specialist paediatric ED (over 85 000 presentations per year), they reckoned on average to see such airway emergencies once every 2 months. The most common

single diagnosis was foreign body inhalation but their series of 22 cases had a wide variety of other causes too. Dealing with these emergencies needs practised team work and ready access to the right paediatric equipment—fine in a big specialist centre but much more challenging elsewhere. *See page 810.*

REHABILITATION FOR BRAIN INJURED CHILDREN

More children now survive acquired brain injury (ABI) that in past times would probably have killed them. These children need expert rehabilitation if they are to get the best functional outcomes, and as Hayes *et al* point out, provision is patchy and variable. Using two complementary data sources they provide a minimum estimate of incidence of ABI for the UK of 3 per 100 000 children per year, which translates to at least 350 events giving rise to brain injured survivors every year. They have not attempted to estimate the current childhood prevalence of neurodisability from ABI. About a third of the cases were due to trauma, and a fifth each from tumours and anoxia. Neurodisability is costly for everyone and good rehabilitation can make a big difference to children's quality of life and society's economic burden. Commissioners, please read. *See page 814.*

THE LAW AND FEMALE GENITAL MUTILATION

FGM has become one of the most important areas of common ground between paediatricians and gynaecologists: what is discovered in adult women may have direct consequences for the risk to their female children. And as in other areas of safeguarding practice, knowledge of the legal framework is very important. Jeremy Weston, QC explains the law in relation to FGM: even if you don't take it all in at first reading, this paper deserves to be bookmarked or downloaded for that moment when you suddenly find you need it. *See page 865.*