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Highlights from this issue

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DISEASES OF POVERTY—PART 1: DENTAL HEALTH

I'm certainly (like many) guilty of affording dental health too little attention. Though 60 000 child inpatient episodes in the UK every year are for dental extraction, poor dental health generally passes under the acute medial radar. It is strongly associated with social inequities, the cause of pain and school loss and given that it is entirely preventable, we should be staggered that 25% of children start school with caries. The first paper in an excellent new series by Jenny Godson and colleagues (***see page 5***) accompanied by MacMahon's compelling findings of greater dental morbidity in looked after children in Scotland (***see page 39***) and contextualised by Sara Hurley's editorial should spur us to address our failings as advocates in this area.

THE RETURNING TRAVELLER: WELL OR UNWELL

Malaria in returning travellers, as is well known, is on the increase and likely to escalate further given the exponential rise in long haul travel. Though an estimated 10% of the current 1500 of the current annual UK 'imported' cases occur in children, in reality, most returning travellers with fever have other diagnoses, most commonly a rather prosaic viral upper respiratory tract infection picked up from fellow airline passengers.

How far then does one go in ruling out malaria in a well appearing child, or put another way, at what stage can one safely infer it has been ruled out? The advent of highly sensitive rapid diagnostic tests (RDTs) based on common plasmodial proteins (particularly histidine rich protein 2) which are highly sensitive (close to 100 % for *P. falciparum*) has not just enhanced detection, but also helped rule out infection. In the UK, this has been particularly useful in situations in which local hospital laboratory exposure to blood films is infrequent and the technicians do not have the experience to confidently exclude infection. Standard advice until now has erred on the cautious with a recommendation to undertake three sets of RDTs (at 0, 24 and 48 hours) with blood films. This might be reassuring but is often impractical involving bringing a family back twice.

William's *et al* excellent Archimedes paper (***see page 109***) reviews the literature and reassures us that, in a well child, a single round of negative tests (RDT, local lab film and regional lab film check) is sufficient to rule out malaria. There are some riders of course in that the studies included adults as well as children and the range of previous malaria exposure was heterogenous, but, to my mind suggests that the source of the fever after a single round of negative tests is almost certainly non-malarial. If one is still worried, then other causes (Dengue and typhoid for example) need to be excluded.

LOOKING AFTER EACH OTHER

For a number of complex reasons, morale in the medical profession is low and stress high. To address this situation, several forward thinking institutions have set up Schwarz Centre Rounds a programme was set up in the 1990s after the death of the American lawyer, Leonard Schwarz from lung cancer and catalysed by his own annotations from this time. They provide a forum for professionals to discuss experiences, each session facilitated by trained mentors and centred on a recent case. John Puntis and colleagues (***see page 11***) present their experience from Leeds, and reading the paper, I couldn't help but wonder why this isn't already standard.

This notion is reinforced by a paper by Hollingsworth *et al* (***see page 14***) in which reactions to trainees to child deaths were surveyed. Many had experienced guilt and 20% reported symptoms suggestive of Post Traumatic Stress Disorder. Martin Ward-Platt's accompanying editorial (***see page 3***) suggests ways in which these situations can be ameliorated, simulation being one.

FLUID RESUSCITATION

It is now almost 7 years since the much discussed 'FEAST' by Maitland *et al* was published in the *New England Journal of Medicine*. It unequivocally showed higher mortality in African children with severe infection given bolus treatment. Though the (patho) physiology has not been fully explained, the findings have posed questions of fluid management in sepsis in high income country settings, specifically that of bolus resuscitation. Understandably, given the stakes, setting up an equivalent trial in the UK has taken time and very careful ethical consideration. O'Hara's paper (***see page 28***) describes the first step towards this trial, a qualitative endorsement by parents with personal past experience that they would consent to randomisation to a low or high volume bolus in a trial.

DISEASES OF POVERTY—PART 2: GLOBAL HEART DISEASE

As Kennedy's review illustrates (***see page 73***), like dental health in high income countries, acquired heart diseases are unified by their association with poverty in low and middle income countries. Rheumatic fever, endomyocardial fibroelastosis, thallasaemia and HIV-related cardiomyopathy and tuberculous pericarditis are all overlooked and potentially preventable, and though not on the WHO Neglected Tropical Disease list, perhaps should be.

Happy New Year
Nick