Highlights from this issue

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CHALLENGING DOGMA

I'll start with a proposition: the overarching role of a medical journal should be challenging dogma in any of its protean forms. For reasons I can't fully explain, unquestioning adherence to any set of clinical beliefs (whether in the form of tests or perceived wisdom) has always made me rather uncomfortable. As a result, one of the pleasures of my role is being able to direct readers to manuscripts which challenge such tenets and nurture alternative viewpoints. This month's highly diverse papers have this feature in common and all reward reading. Enjoy them

In a complex, elegant study, which is this month's Editor's Choice, Oliver and colleagues (*see page 327*) estimated the excess (potentially avoidable) risk of rehospitalisation of New Zealand children admitted at least once between 2000 and 2015 attributable to potentially modifiable adverse home living conditions. These included: social environmental conditions; a subset including home environment; overcrowding and a group at risk of Group A streptococcal infection. Adjusted HRs ranged from 2.3 to 3.6 respectively for rehospitalisation or death from any cause, risks that are perhaps unsurprising. What should stimulate thought, though, is the vigour with which the New Zealand government has delivered interventions, for example 'Healthy Housing' (reducing humidity and mould) and 'Warm Up' (insulation) to those families identified in need. Shouldn't any discharge summary include at least an attempt at assessing whether the environment to which a child is returning is at least an adequate one? Shouldn't we all be trying to intervene when it isn't?

With this in mind, I suggest you read Neena Modi's leading article, 'The Case for Child Health' (*see page 316*) which assesses progress made by each of the individual nations in the UK a year after the Royal College of Paediatrics and Child Health report, 'The State of Child Health'. Though there are some heartening positives, there is much inertia, a situation for which we all have some accountability.

I like pragmatic trials which address practical problems. Drooling in children with neurodisability, certainly fits the bill: skin breakdown, damage to clothing, extra washing, the social implications make it a very real issue for these children and their parents. Both hyoscine patches and oral glycopyrronium are in widespread use (often concomitantly), but little is known about their relative merits. Parr and colleagues (*see page 371*) answer this question in a randomised control trial in which children with excess drooling were randomised to one of the two drugs and relative effectiveness as measured by the previously validated drooling impact scale (DIS). Both drugs significantly reduced DIS, but, the rate of treatment cessation or switch of treatment as a result of side effects was higher in the hyoscine arm. In general, these were 'predictable' anticholinergic effects (dry mouth, mydriasis), but the patches also resulted in a number of unexpected ones, for example, local skin reactions; unsteadiness and hyperactivity.

ESTIMATING THE INESTIMABLE

Most of us are aware that the assessment of degree of dehydration is at best a rough guess, and that the signs on which the estimates are made (skin turgor, heart rate, fullness of fontanelle, degree of biochemical derangement) are all highly subjective. In low and middle income countries, of course the evaluation can be compounded by co-existent acute malnutrition when estimating the attributable portion of weight loss to water or tissue becomes even harder. The findings of Falszewska's systematic review (*see page 383*) of three common scoring systems (the clinical dehydration scale, the Gorelick and the WHO) in the assessment of hydration in acute gastroenteritis should, therefore, come as no surprise. None of the indices shone though the CDS (an additive score) performed better in high income settings. Where the LR+ of 3.9 to 11.8 of ruling dehydration in but was less good at ruling it out (LR- 0.55 to 0.71). The gold standard, of course is the percentage deficit in true (immediate

pre-admission) weight measured with compatible scales (another major source of error), but this is so rarely available that we are left... guessing.

THE 24 WEEK GESTATION BABY AT SCHOOL LEAVING AGE

The original Epicure 1 study of outcomes in extreme prematurity (EP, babies born up to 25 weeks of completed gestation in the UK between March and December 1995) answered many questions about immediate survival and early outcomes. Linsell's further analysis (*see page 363*) of the surviving members of the cohort (now in their early 20s) tells us much more about their cognitive outcomes. Assessments at the ages of 2 to 3 years (Bayley), 6 to 9 years (Kauffman) and 19 years (Wechsler) showed consistently poorer scores, particularly marked in boys and those with a neonatal brain injury. Of most surprise is the stability of the deficit, that early deficits neither narrowed nor broadened. This suggests that cause for optimism for a well performing EP 3-year-old is reasonable, but for a contemporary that is lagging, should be guarded. Though the more recent (2006) Epicure two will no doubt augment these findings, the strong message from this cohort at least is that plasticity of development of the EP brain is limited.

A NEW LENS

Saint-Exupéry's much loved book, 'The Little Prince', has been pored over by generations of children and their parents, its meanings scrutinised from numerous angles. Lemay's paper in this month's 'Voices' (*see page 389*) offers a further, personal interpretation: that the eponymous protagonist had Asperger's; his lack of reciprocation, bewilderment over roles and expressionlessness given as arguments for this hypothesis. That this theory can neither be proved (the author having died in 1944), should not detract from the pleasure of viewing something familiar through a new lens. Isn't that what all good literature (clinical or otherwise) should be doing?