Highlights from this issue

Nick Brown, *Editor in Chief*

IT ALL DEPENDS WHERE YOU DISEMBARK

Whimsical metaphor? Not intentionally. In the context of this (or any other month's issue), the role of the column in guiding a reader to a station of disembarkation/paper is very important. This month's issue is very strong on global health, endocrinology and infectious disease. None of the excellent papers I describe are difficult conceptually, all are practical and each rewarded reading. I know you will enjoy them too.

NEW WHO INITIATIVES

Last month after both extensive and intensive consultations, WHO released a new set of standards aimed at improving child and adolescent health. These are centred on eight key areas, and though clinical aspects form one spoke, they take us a step beyond standard practice guidance in that central tenets are child and parent appropriateness, quality improvement and the psychological and environmental aspects of illness. Like the Millennium and Sustainable Development Goals, each area has targets with which to guide local and national progress, and Trevor Duke's editorial (*see page 625*) helps place these important new standards in perspective. We urge anyone involved in the implementation of these standards in low-income and middle-income countries to share their experience of this important new initiative.

This issue also sees an important study by Sandakabatu and colleagues from the Solomon Islands (*see page 685*) in which, in the light of new WHO recommendations, they initiated the audit of all neonatal and child deaths in early 2017. The process is philosophically identical to that in the UK

with a confidential, no-blame approach. Many of the potentially modifiable issues such as communication and prior non-engagement with health services will be familiar, and context-specific ones such as the lack of access to boats to travel to the nearest secondary care show what extraordinary work is undertaken in this setting.

GENDER DYSPHORIA

Though there is widespread awareness of the issues around it, few feel equipped to help the troubled adolescent who presents with a gender dysphoria. This makes the comprehensive review of the area, age-appropriate interventions and analysis of their own work in London and Leeds by Gary Butler (*see page 631*) even more welcome. This is a paper that deserves reading, reflection and re-reading. It is now augmented by a podcast based on the paper (www.goo.gl/GCpa53) and is my editor's choice for the month.

THYROTOXICOSIS

I cannot be alone in having been lulled into thinking through standard physiology texts that thyrotoxicosis is straightforward to treat: just block hormone production and wait for the overstimulation to settle. This, of course, is a misconception and a course of antithyroid drug treatment usually not the single solution we want it to be. Graves' (defined by anti-TSH receptor antibody) is a very different beast to the relatively avuncular, postviral Hashimoto's (characterised by thyroid peroxidase antibodies). The two are often confused and, as Tim Cheetham's editorial (*see page 627*) on the paper by Kourime *et al* (*see page 637*) shows the importance of early differentiation given the side effects of medical therapy and remission rates of only 20% of 'real Graves' on drug treatment.

DEFERVESCENCE IN A YOUNG CHILD: FALSELY REASSURING

Despite decades of research and interrogation of promising biomarkers, there are

still areas of grey in the approach to the young febrile child. The key of course is not to miss invasive bacterial infection (IBI), and though many would feel reassured by defervescence before presentation, the results of a large series from Mintegi *et al* in Northern Spain (*see page 665*) casts some doubt on this aphorism. The authors examined 2470 babies less than 90 days old who had had an axillary or rectal temperature $>38^{\circ}\text{C}$ at home. Of these, 678 were afebrile by the time of presentation and 1728 still febrile. Though there were no cases of meningitis in the afebrile group, the prevalence of total IBI was exactly the same (2.4%) in each group. To further complicate interpretation, the vast majority of the babies (with and without IBI) appeared well and they conclude that defervescence and reassuring appearance cannot exclude IBI.

PNEUMOCOCCAL DISEASE IN SICKLE CELL DISEASE

First the positives: since screening for sickle cell disease was introduced to the UK programme in 2006, almost all affected children have been identified neonatally. In conjunction with the introduction of the 13 valent pneumococcal vaccine (Prevenar 13) in 2010, the rates of invasive disease (IPD) have plummeted from the jaw-dropping 600-fold relative risk in the antecedent era. However, as Ware's editorial (*see page 628*) on Oligbu *et al*'s paper (*see page 643*) shows, there is still some way to go. In a 4-year analysis in the immediate post-enhanced prevenar era, the relative risk of IPD is still 49 in children with sickle cell disease compared with unaffected controls. Though most cases were due to non-vaccine covered serotypes (particularly 15), all were caused by penicillin-sensitive organisms. It is well known that adherence to penicillin V prophylaxis is variable, and our duty (even more so in the light of these findings) is to reinforce the importance of compliance to parents of children with sickle cell disease.

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