



Highlights from this issue

Nick Brown , Editor-in-Chief

Some of you will receive this edition on holiday: some of you will have had to delay long yearned for breaks after your children's schools have gingerly put their toes in the lockdown twilight era. But, rather than dwell on pandemic related uncertainty which we've all been submerged for several months, let's briefly put the microscope somewhere else.

BILIARY ATRESIA

Despite repeated emphasis of the potential implications of prolonged, conjugated, hyperbilirubinaemia and the importance of stool colour, rates of late detected biliary atresia in high income countries have remained effectively static. Untreated, biliary atresia leads to liver failure and death: early palliative surgery in the form of the time honoured Kasai procedure prolongs transplant free survival by years, though the traditional rather arbitrary 2 month cut-off for the procedure is now widely felt to be too relaxed. The clinical assessment approach, in short is alone insufficient, and improved screening embedded into national programmes is the only real alternative. There are two options: parental reporting of stool colour which has already had considerable success in Japan and Taiwan and the incorporation of conjugated bilirubin analysis in the newborn blood spot screen (NBS). Jiachen Zheng's analysis of comparative rates of detection in Shenzhen, China in the 2 years before and after the introduction of the stool screening chart (SCC) provides evidence for effectiveness of this simple parent-reported method. Age at Kasai fell from (mean) 81 to 56 days and transplant free survival at 2 years rose from 44% to 52%. Patrick McKiernan's editorial puts the findings into perspective and argues the case for (and there is already some data from the

US) advantages of the NBS approach. Whichever approach (and this is setting dependent) is adopted the days of the primary care referral-secondary care assessment pathway are now as obsolete as the perennially contaminated bag urine samples once considered helpful. *See pages 720 and 709*

WHO HOSPITAL CARE GUIDELINES

Trevor Duke chronicles the history of the WHO paediatric hospital care guidelines, an initiative that began only 15 years ago after the seminal guidance for acute severe malnutrition and infection which itself was based on an adaptation for secondary care us of the integrated management of childhood illness (IMCI) guidelines launched in the mid 1990s for primary care which has (philosophically at least) survived the rigours of time.

What should we expect the new guidance to address: adolescent health, chronic disease, refinements in the management of HIV and TB according to resistance and, like the 2013 predecessor regional adaptation, or something else? *See page 711*

ANTIMICROBIAL STEWARDSHIP: VIETNAMESE EXPERIENCE

Pneumonia is a syndromal diagnosis, defined by the WHO as a constellation of signs primarily age adjusted respiratory rate. In the latest classification (2014) there are only two phenotypes. fast breathing (with or without indrawing) and fast breathing with danger signs (lethargy, convulsions, hypoxia), treatment of the former, oral amoxicillin for 3–5 days and the latter (much rarer) admission and parenteral treatment. Phuong Nguyen and colleagues' analysis of antibiotic prescribing practice in non-severe pneumonia in Da Nang, Vietnam, makes two highly important observations about rates of antibiotic resistance and avoidable hospitalisation. Of 2911 children admitted with pneumonia, 2735 (94.0%) were classified as 'non-severe': of these 12.4% received IV treatment accounting for 68.2% of parenteral courses. In keeping with other SE Asian (but not in sub Saharan African) countries one reason is socio-economic as young children's hospital care is funded centrally

so admission paradoxically, 'cheaper' in payment for care terms (if not socially) for the family than the WHO recommended outpatient treatment with the additional risk of exposure to multiresistant bacteria. *See page 713*

PRIMARY CILIARY DYSKINESIA (PCD)

Far from being the benign entity it is often perceived to be, PCD results in suppurative lung disease, chronic otitis media and deafness, sinusitis and infertility. Those without the classic early clue, situs inversus, are picked up later and often not diagnosed and treated until school age. Bruna Rubbo and colleagues' analysis of four PCD centres comparing respiratory function with children with cystic fibrosis in England is salutary with mean (SD) FEV1 z-scores for children with PCD were -1.9 (1.4) and FVC z-scores were -1.3 (1.5) less than their counterparts themselves with chronic respiratory illness. *See page 731*

MENINGOCOCCAL VACCINATION

The gestation of meningococcal B vaccination was, for primarily immunological reasons long and complicated, completed decades after effective immunisations for types A, C, W and Y were developed and introduced. It was finally licensed in the UK in 2013 and introduced into the primary vaccination programme in 2015. Though the trial evidence was promising, Catherine Isitt's paper of real life experience since describes how it has surpassed expectations in terms of the reduction of incidence of invasive meningococcal B disease. What else has been learnt in the 5 years since? That a number of children will develop post vaccine fever which might result in acute referral as a reaction cannot be discriminated from invasive infection, but, that prophylaxis with paracetamol does not impede immunogenicity. There are questions left: do children with non-response need immunological investigation; how can adolescent cover be improved; does B vaccine prevent invasive disease from other serotypes... but, we've come a long way. *See page 784*

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