LITERALLY LITERACY

Though this issue won’t appear for another 3-4 weeks, given the painful events unraveling in Afghanistan, it would feel banal to the point of negligence to fail to ask ‘where are we going’ in terms of global human rights.

Many years ago, I took a short course on ‘primary health care in low and middle countries’ to equip myself with some knowledge of the public health issues I was likely to encounter first in Sudan and later Afghanistan. Though the teaching was a little too ‘touchy feely’ for my taste, it left an impression based on one talk and one message: female literacy. Once assimilated, I realised that this was central to everything.

I was based close to Kabul, during the immediate, relatively upbeat (if not as open as the 1970s) post-Soviet withdrawal era and have maintained some contact in the form of research collaborations with colleagues in the Afghan Ministry of Health. In parallel, we have seen the tantalising promise of a future of freedom and children’s futures and women’s rights inching in Afghanistan, it would feel banal to turn to the off-shelf priorities of a footballer or mid-ranking cabinet member don’t forget that if classrooms can be kept open, then there is still hope.

GLOBAL CHILD HEALTH: MATERNAL INFECTIO AND PERINATAL OUTCOME

Continuing the neonatal sepsis theme discussed by Carolin Fleischmann and colleagues in the August issue (https://adc.bmj.com/content/106/8/745) Adama Baguiya’s WHO maternal sepsis (GLOSS) group takes another angle, the identification of high risk babies by the mothers’ peripartum condition. Using data from 43 LMICs, neonatal outcomes of mothers with suspected or proven sepsis were compared with those in whom there were no concerns. The direction of effect (predictive) was perhaps not surprising, though the magnitude was. A third of the babies of these women had adverse outcomes: 25% near miss events (outcomes requiring intervention or resuscitation of some sort) and a 10% mortality with an OR of 3.8 (95% CI 2.0 to 7.1) for the most severely unwell mothers. How then can these women be identified earlier before both they and the fetus starts to decompensate? See page 946

OPiates in Analgesia

We all have a preferred opiate for analgesia resistant to first and second line alternatives and this particular choice has been, for as long as I can remember, if not divisive then factionalising.

From buprenorphine patches to intranasal lentyl to oral dextromomamide (the latter admittedly now largely a museum piece) to codeine, each has its (often vocal) proponents, the volume of their arguments not necessarily a correlate of analgesic effect.

In the Drugs and Therapeutics section, Sarah Spenard and colleagues address this chestnut in their systematic review of the literature comparing morphine and hydromorphone, the turn to opioid agonism of a future of freedom and children’s futures and women’s rights. They found high quality evidence from 4 RCTs concluding there was nothing to choose between them in terms of therapeutic or side effects. So, rather than weighing up which opiate, the only question worth asking is ‘is there a reason not to start one now?’ in the face of a child struggling on high dose NSAID treatment. See page 1002

SAFETY REPORTING

We are the proud discoverers of a new antimicrobial drug, let’s call it ‘viroblast 21’, the performance of which in phase two trials has been (our brochures proclaim) ‘breathtaking’. Agog with excitement, we proceed to the ‘definitive’ randomised controlled trial in children admitted to PICU for respiratory support. The ‘fully adjusted analyses’ (inverted commas, of course intentional) repay the faith we had in the drug, a ‘jaw dropping’ protective HR in time to recovery of 0.2 (95% CI 0.1 to 0.35). The tension is released and celebrations can begin... or can they? The message in Taco Jan Pils’ and colleagues’ systematic review of trials reporting is that, even now, in the era of EQUATOR, CONSORT, siblings and half siblings safety data is often overlooked. Though reporting has improved over the decade since their previous review, it’s baffling that it isn’t 100%. Part of the story is missing. Taking a tangential trajectory, it would be reasonable to argue that the sort of safety reporting leaves a few more loopholes: I want to know whether children can swallow the preparation; whether it tastes good (or at least isn’t emetogenic); and that the cost is not crippling for the health service or patients and parents by which it will ultimately be financed. This too (the economic burden) is also to my mind a side effect: where resources are finite, something else will have to give. Maybe that mouthwatering ‘effect size’ didn’t tell us everything we need to know. See page 1010

FIXING A HOLE WHERE THE RAIN GETS IN

The reality is that much of what we do, despite the best public health preventative measures is reactive. The asthmatic child’s parents of ‘who only ever smoke outside’ are advised to stop or get help/gum/patches.

I’m digressing but only slightly as, what I’m getting at are the upstream (preventative) vs downstream (symptomatic) approaches. Until recently, all treatment in cystic fibrosis was, by necessity, reactive/downstream: the advent of the CF transmembrane modulator family, correctors and potentiators has changed all this. Iolo Doull’s compelling review from the discovery of the molecule to the consistent improvements in all objective measures of lung and overall health by its augmentation testifies to this. This is exciting for other reasons too: in the same way that anti-retroviral treatment in HIV became bolder and gathered pace, there is impetus for novel orphan drug development with implications beyond CF alone. See page 941

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