



Nick Brown , *Editor in Chief*

END OF TERM REPORT

'Brown: you may discuss your report with the head now. You should know, there are some issues.' Many of you will have similar recollections of mid-July during their schooldays. The annual feedback lurking, snake-like in the reeds, freedom never granted until the teachers' handwritten, often indecipherable words had been parentally decoded at home, my own Achilles' heels art and English literature perennial causes of teachers' deep sighs. I acknowledge that the stick men figures of my primary school art failed to evolve into anything more than uncannily similar stick men figures over the course of my pre-teenage years, the point at which my metaphorical knotted sheets and I furnished an escape. Are we also, collectively, guilty of leaving our socks proverbially at ankle length in places?

ASTHMA: WHAT ARE THE PRIORITIES?

We kick off with a blistering pair of editorials which eviscerate a common practice from opposite, but not necessarily, mutually exclusive angles. The first is by Ian Sinha and argues the case for the replacement of prednisolone with dexamethasone in acute asthma attacks. The ubiquitous prednisolone is, its detractors assert, known for its (gustatory, olfactory and visual) unpalatability. Once sampled, no child ever trusts pink medicine again – its emetogenic capacity and potential for non-compliance given the 3 day rather than 1 day course often cited as additional drawbacks. Mark Levy and colleagues challenge the need for the abandonment of prednisolone largely based on the lack of hard evidence. This is where interpretation has to be disentangled from personal biases: not easy and the reality is that even the most robust meta-analyses can't always furnish us with 'the answers'. I could, but won't take sides on this (just now) as it would spoil your fun, but perhaps this is too close to call and, as long as the right children

Department of Women's and Children's Health, International Maternal and Child Health (IMCH), Uppsala University, Uppsala, Sweden; Department of Paediatrics, Länssjukhuset Gävle-Sandviken, Gävle, Sweden; Department of Child Health, Aga Khan University, Karachi, Pakistan

Correspondence to Dr Nick Brown, Department of Women's and Children's Health, International Maternal and Child Health (IMCH), Uppsala University, Uppsala 801 87, Sweden; nickjwbrown@gmail.com

(school age) get some steroids (of one hue or another) early on and the wrong children (most preschoolers) don't that might be a reasonable compromise. There are other high-profile priorities like the use of high protracted courses of beta agonists and after discharge underuse of inhaled steroid-LABA combinations: I'm already looking forward to the next round of discussions. The UK (and we can shoe-gaze all we like) is a perennial 'could do better'/end of year report C-performer. Not as bad as my F grade art, of course, but, how hard can it be to score at least a B grade? *See pages 729 and 730*

NEONATAL SEPSIS: NEW DATA

Though a great deal of credit is due for progress during the Millennium and early Sustainable Development goal eras, the data can't disguise the areas where little changed. Until recently at least, perinatal mortality was one. A rule of thumb reminder: in most low and middle income countries infant mortality accounts for about two thirds of all under 5 mortality. Of infant mortality, about two thirds is neonatal (first month) and, of neonatal, two thirds perinatal, deaths in the first week. Causes are consistent: prematurity, asphyxia and sepsis, the dysregulated host immune response to infection to which neonates are exquisitely sensitive. We like to think we have a ballpark idea of the burden of peri and neonatal death globally, but this ballpark is a very elastic one. Carolin Fleischmann and colleagues' meticulous systematic review and meta-analysis brings some clarity, not only in overall sepsis load, but (and this is particularly useful in antibiotic selection) the early and late onset phenotypes. Of the total screened 26 studies published between 1979 and 2019 met the criteria (including a tight sepsis definition) were included accounting for 2.8 million live births and close to 30,000 sepsis. Random-effects MA estimated an incidence rate of 2,824/100,000 births with a case fatality of 17.6%. Between 2009 and 2018, the incidence was markedly worse at 3,390. This isn't a finding we can dismiss simply under the smokescreen of ascertainment bias and improvement of criteria. Take a look at the beta lactam, fourth generation cephalosporin, carbapenem and linezolid resistance patterns in other studies and one can only conclude this is not good news. *See page 745*

NON-ACCIDENTAL INJURY: MORE SCIENCE: NEW DATA

The TEN4 Bruise Clinical Decision Rule (BCDR) was first reported by Pierce in 2010. It was estimated that 'bruising on the torso, ear, or neck for a child <48 months of age and bruising in any region for an infant <4 months of age, in the absence of a publicly witnessed injury' had a sensitivity of 97% and a specificity of 84% for predicting abuse. Using data from previous studies on patterns in day to day bruising, NAI and inherited bleeding disorders, Alison Kemp and colleagues refine the tool to test its ability to differentiate between bruise distribution phenotypes. Applying TEN4 to to children under 4 years of age, with at least one bruise had an estimated sensitivity of 69% and specificity for abuse of 74%, figures that will ultimately inform how we report and a court interprets findings in an area where uncertainty is the rule. *See page 774*

CAN ONE AFFORD TO SIMPLY WAIT?

Other than the surgical approach having changed from scalpel to laparoscope, the individual and family experience of appendicitis as a package in terms of inpatient time, discomfort and cost has changed little in the recent past. For such a common entity, exploring new alternatives was always going to be necessary and the surgery vs antibiotic/expectant hypothesis is one such avenue. The CONTRACT study, one of a series of randomised controlled trials tests the effectiveness of treating children with uncomplicated (for example, unperforated) appendicitis with parenteral antibiotics rather than surgery. Bold, but not unreasonable, given the objective equipoise and long experience of this approach in some countries. It is likely that the results of these RCTs will determine the route children take for years if not decades. The trial feasibility study undertaken by Nigel Hall and colleagues lent weight to: parents' enthusiasm (50% enrolled after being approached); acceptability of randomisation and patient and surgeon adherence to trial procedures. *See page 764*

ORCID ID

Nick Brown <http://orcid.org/0000-0003-1789-0436>