



Highlights from this issue

Nick Brown , Editor-in-Chief**VOGUE?**

The state of being 'in vogue' implies an ephemeral, transitory period where an idea, person, subject or even philosophy catches the broader eye and consciousness. The 'entity' enjoys a Warholian 15 min of fame before disappearing entirely or at least from view. That the internet can now capture these '15 min' spells affords them greater long term accessibility, but does nothing for their active shelf lives, inevitably, short as a result of a societal concentration spans. Greater permanence is possible for subjects not in vogue, but of perpetual importance. These problems have eluded, evaded and defied us for decades, centuries, sometimes millennia, but are those where advances are ground-breaking, permanent and, well, exciting in their 'unvogueishness'.

DRUGS: PART 1 – TUBERCULOUS MENINGITIS

Anyone who has witnessed a child succumbing inexorably to tuberculous meningitis will recognise the feeling of helplessness despite seemingly appropriate (isoniazid, rifampicin, pyrazinamide and ethionamide) treatment. This gives the pharmacokinetic paper in, the ever thought-provoking, Drug and Therapeutics section by Rovina Ruslami and colleagues in an Indonesian-Dutch collaboration, even more resonance. In several children CSF drug levels on standard doses were suboptimal and, given data from higher dose treatment in South Africa deserves wider consideration, at least where drug induced liver injury (common but reversible) can be monitored. This work, that has ramifications way beyond the PK data is thoughtfully discussed in Ben Marais' editorial. It includes an examination of the key practical (and painful) issues: late presentation; the lack of access to GeneExpertMTB and nucleic acid amplification; lack of culture facilities; the equipoise between recommended and short-term higher dose treatment and the

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ceiling effect with standard antimicrobials which alone cannot rein in the inflammatory response underlying the neurological damage so commonly seen. *See pages 70 and 68*

DRUGS: PART 2 – MONOCLONAL THERAPY

The rise of biological therapies has generated a raft of peri and post-partum questions unthinkable a decade ago. Take, for example a mother whose rheumatoid arthritis has been well controlled with etanercept pre-conceptually and certolizumab (with very low transplacental transfer) during the pregnancy. She wonders when her baby can start receiving routine vaccinations. Bryan Finn's enlightening Archimedes puts the theoretical risks in context and reassurance on safety of later live vaccination. *See page 93*

DECISION SHARING

Two ethics pieces, an editorial by Dominic Wilkinson and Clinical Law commentary by Rob Wheeler have, despite their ostensibly unconnected themes more in common than first meets the eye: the role of parents.

In the editorial, several common scenarios in which there is parent-parent or parent child disharmony (or at least the unfeasibility of demonstrating harmony) are discussed, solutions essentially resting on Gillick level maturity, general recommendations, precedent and doing no harm. In the latter, the argument for parental inclusion on clinical ethics committees (which are purely advisory rather than statutory) is eloquently made. *See pages 3 and 12*

UK CHILD MORTALITY DURING THE PANDEMIC

Irrespective of the lens through which you view the current stage of the pandemic, there can be no ambiguity about the findings from Karen Luyt and colleagues' analysis of the National Child Mortality Database. Other than the well-known ethnic variations in susceptibility, mortality decreased during the pandemic and, though decreased exposures to close-contact transmissible infection is likely to have been a factor, the consistent non-susceptibility (RR 0.93, 95% CICI 0.84 to 1.02) and of children is, still, at least for the time being, the headline. *See pages 14*

'BLUE-INHALER-ONLY' SYNDROME

Just as in secondary care, primary care doctors need to identify at risk asthmatic children in terms of treatment, adherence, education on warning signs and the avoidance of triggers, household smoking, the *bete noir* par excellence. Lo and colleagues examined a range of potential predictors in 414 children from 10 English practices before and after the initiation of provision of exhaled nitric oxide (FeNO) and spirometry as adjuncts to clinical assessment.

Independent predictors included previous episodes, higher practice deprivation codes, higher FeNO, non-Asian descent and, tellingly the Asthma Medication Ratio (AMR) a measure of the number of (prophylactic) inhaled corticosteroids (ICS) prescriptions divided by the number of reliever (SABA). This, by implication, suggests that those with poorer control are more likely to rely on relief after development of symptoms than prevention. Low AMR at baseline and a reduction (less ICS and more SABA use) during the study predicted attacks (OR 3.0, 95% CI 1.4 to 6.2). We could have been having this conversation 25 years ago—we did, actually—so why are we still handwringing over compliance issues? The motivator in similar situations is accountability (twas ever thus) and that particular nettle perhaps just hasn't been grasped with the gusto it deserves... *See page 21*

GENETICS OF SYNCOPE

The genetics of cardiac arrhythmias and cardiomyopathies has had a long gestation, but, with the advent of whole exome sequencing, is now accelerating. Genotyping is much more than identifying a cause as Shuenn-Nan Chiu and colleagues' data demonstrate in their population of children with sudden cardiac arrest. The yield for the WES cardiomyopathy and channelopathy screen was 85%, the children whose management was changed on the basis of a positive test faring better in terms of transplant free survival and need for ECD resuscitation. *See page 41*

That's all for now
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