HURDLERS

Though (or maybe because) I was working in Khartoum, Sudan as events reached their climax, I still have vivid memories of the 1989 fall of ‘The Wall’ in Berlin, the city’s (and country’s) subsequent reunification and the catalytic effect it had on the rest of Eastern Europe. This was long before the internet and my updates were informed wholly by the BBC World Service. Despite the crackly reception and the near overwhelming heat, sweat and submersion in darkness resulting from fan failure from the daily evening power cut, I felt as close to the ground as I would have done had I had access to television. This had been fermenting for years beforehand, but illustrated (emotionally and politically) how human will can overcome structural manacling. Barriers are not a phenomenon unique to geopolitics, though. Medicine too, is riddled with them, real, imagined and metaphorical. Some, paradoxically, are invisible because of their pervasiveness.

PNEUMONIA AND TREATMENT: GLOBAL HEALTH

There’s been a buzz in the air this week as the new WHO primary care handbook guidelines for children and adolescents have been launched. This is a once in a decade event, a huge undertaking, based on new evidence, each iteration influencing a generation of health workers. Each clinical scenario begins with presentation at a primary health facility the starting point. A pre-requisite, of course, is that the child can be assessed face to face by a health worker. The task of the latter is to interpret the combination of symptoms, follow the appropriate algorithm and treat and/or refer as appropriate.

Let’s go back a step to the pre-presentation stage. Does the trajectory change if there are pre-primary (complete or partial) barriers to presentation? Of course, and this is where qualitative public health implementation research earns its living. It’s hard to think of a better illustration than Kamal Choudhury and colleagues work from Bangladesh in which exploring the causes for delay in parental care seeking in children with pneumonia. The reasons are complex and range from cost, to obtaining spousal ‘permission’, to initial traditional healer consultation and use of herbal remedies to the logistics of transport to simple awareness of the facilities. The last few years have seen some attenuation in these barriers though the use of tele-consultation, the use of apps (for example oxygen saturation) and time will tell whether COVID-19 enforced distance management will enhance cover with these alternatives or were a hiccup in progress in optimising recognition at home and presentation. See page 436

REFUGEES

As a new wave of refugees from Ukraine begin their westward journeys, they follow in the footsteps of their Syrian, Iraqi, Afghan and many other predecessors. They have a lot in common with each other. As a result of witnessed or direct trauma, they have a degree of physical or psychological scarring on resettlement. The story, though, doesn’t stop there. Two papers (Sarah Cherian in Perth, Western Australia and Alice Armitage, London) re-emphasise that care provision (screening, psychological support, child protection issues) is dependent on knowing ‘they are there’. This is not always straightforward: the use of multiple names, unclear age (about which there’s already a sizeable literature) and clinic non-attendance are common and serve only to increase their vulnerability. See pages 461 and 456

NON-TUBERCULOUS MYCOBACTERIA IN CYSTIC FIBROSIS

A decade or so ago, there was a ripple of excitement in the cystic fibrosis (CF) community about the association of the presence of atypical mycobacteria (non tuberculous mycobacteria/ NTM) and respiratory relapses. These organisms were, after all, ‘treatable’. At that point, though hypothesis-generating, the data wasn’t robust enough for causal inference. Gemma Saint and colleagues compare outcomes of treatment of NTM infection in 2017 from 11 CF centres with 2006 figures and, though far from clear cut suggest that, there are benefits in lung function associated with intervening.

As in any observational epidemiology, this needs some context around barriers to drawing conclusions which the authors, very appropriately resist: the ‘right treatment’ (drug and duration) is unclear (look at the uncertainty around cervical NTM adenopathy, with little to distinguish a wholly conservative approach with nodulecytectomy); the possibility of selection bias – are those in whom NTM is identified the inherently higher risk?; confounding by intention; the mechanism of (purported) benefit... antibacterial or anti-inflammatory; the interpretation in view of the now ubiquitous use of CF transmembrane regulators barely available even in the latter collection period. The bottom line, though, is the treatment associated benefits which can’t be ignored. See page 479

MISSING THE BATON

As John Warner’s reflective piece emphasises, even the best cited paper in the highest impact factor journal does not necessarily translate into policy change. The obstacle that is implementation science is perhaps the single largest barrier to the completion of the hypothesis-observational testing – RCT – change in management chain. Many of us have had firsthand experience: the buzz of acceptance of a manuscript, over time, being supplanted by frustration at the inertia at policy level in terms of incorporating findings into guidance. Whether this is conservatism, budget-related, conflict of interest, a lack of understanding or simply a reflection of the speed at which cogs move is debatable. Either way, this is arguably the biggest barrier... but, to name but a few, as recent experience with COVID-19 and HPV vaccination, maternal to child HIV transmission prevention, CFTR treatment illustrate, the process can be catalysed when the will to do so is there.

So, we need to decide. Do we shrug and take the easy option by blaming politicians entirely for this block? No, as in any relay, there’s joint responsibility for the baton, the buck stopping with everyone in the chain. Our duty is, literally, to keep shouting. See page 505

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