Atoms

Nick Brown , *Editor in Chief*

'TAKE 5'

The camera swings smoothly from the penumbral apartment view to a vertiginous angle above the staircase. The sole source of illumination a swaying, flickering lightbulb too intermittent to allow you to determine whether the silhouette near the cellar door is real or… the ostentatious Hitchcockian flourish serving only to cast more doubt cast on what your senses are telling you. "Cut" calls the voice from the director's chair, face hidden by a diametrically challenged trilby "no one will guess which of the protagonists is which".

A RASH OF MISUNDERSTANDING

It's late at night, you've just the seen a child with an archetypal strep throat, the rapid antigen test confirming what you already knew. You're child about to press beta lactam on the e prescribing system when you remember to ask about allergies. "Penicillin brought her out in spots last time" comes the counter parry and, without time, energy or resources to explore this any further, resign yourself to a search for what you know will be a second best alternative and order the macrolide you know has a population level reputation for its capacity to generate antimicrobial resistance. Two linked papers (Paul Turner's editorial and Kene Maduemen and colleagues' survey report demonstrate the threshold at which this information is generally accepted, unchallenged and the ease by which through a straightforward outpatient oral provocation the label can be peeled off. *See page 329 and 364*

BLURRED BOUNDARIES

Think of the old black and white picture: the avoidance of eye and other contact, watchfulness, withdrawal, the archetypal 1950s child maltreatment image. But is this phenotype unique to the abused? There are two diagnostic DSM codes for the behavioural problems associated with former maltreatment: reactive attachment disorder (emotional and social inhibition) and disinhibited social engagement disorder (with additional irritability). These can be distinguished but the overlap between autistic spectrum disorder and RAD is less clear. Jeanne Wolstencroft and colleagues' intriguing comparison of two groups of children, outpatients at the Attachment and Trauma Clinic and the established ASD group, those diagnosed by the Social and Communication Disorder service assessed at Great Ormond St Hospital London suggests some overlap between these groups. Though there were subtle differences in behaviour (repetitive and stereotypical), 60% of the former maltreated group fulfilled criteria for ASD diagnosis on a standard questionnaire. The aphorism asserting 'just because you have one problem doesn't mean you don't have another' rings loud. *See page 393*

GLOBAL CHILD HEALTH: GROWTH – PART 1

The debate about the appropriateness, or otherwise, of generic global growth charts becomes more intriguing. The standard 2018 WHO charts on which international comparisons are made were based on data from South America, Sub Saharan and North Africa, South and South East Asia and Europe and were a clear step up in terms of generalisability from their predecessors. There were, though, marked differences for term birth weight even after adjustment for gestation, in other words the degree of intrauterine growth restrictions, India standing out. In the interim, proponents of widely used alternatives, the Fenton and Intergrowth charts (the discourse too detailed to expand on here) have been vocal in their arguments for their chart of preference. In the first of two growth-related studies, Sonoko Sensaki and colleagues from the National University of Singapore, compare fetal growth and birth weight in babies of Malay, Indian and Chinese origin using data from both a 1990s and 2010s cohorts and compared them to Fenton chart. In short, the term birthweights overall were smaller than 'expected' on standard charts, Indian neonates more constrained, the main reason appearing to be a slowing of fetal growth between 37 weeks and term. *See page 368*

GLOBAL CHILD HEALTH: GROWTH – PART 2

Head circumference is arguably an even harder parameter on which to draw conclusions, certainly if only single plots are available, the rate of change being much more informative. Lai Ling Hui and colleagues in Hong Kong and the UK Twelve references from eleven countries/regions (Belgium, China, Ethiopia, Germany, Hong Kong, India, Japan, Norway, Saudi Arabia, UK, and USA) were included. Median head circumference was larger than that for the Multicentre Growth Reference Study populations in both sexes in all these populations except for Japanese and Chinese children aged 1 month and Indians. Overall, at 12/24 months 8–9% children were be classified as macrocephalic and 2% would be classified as microcephalic, compared with the expected 3%, but with marked inter-country differences. *See page 374*

GLOBAL CHILD HEALTH: GROWTH – PART 3

Monoclonal antibody treatment is now (in addition to its protean other uses) an option for treating in X linked hypophosphataemia, the the most common non- dietary cause of rickets. Burosumab a fibroblast growth factor antagonist has been approved, the landmark studies suggesting a mechanism mediated through improved renal retention of phosphate and 1 hydroxylation of vitamin D, serum phosphate the latter having become the 'marker of response' of choice. The data Emma Walker and colleagues in London present suggest this is not as clearcut. In their group normal growth was achieved in many despite only modest responses in phosphate. *See page 380*

'In the can' the gravelly timbre echoes – the only sign of her presence, the thick cloud of acrid cigar smoke inching its way upwards towards the lights stanchion.

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