

Nick Brown , *Editor in Chief*

never collected their prescriptions, the message lost somewhere in translation after leaving the building. Those who did or collected prescriptions from community pharmacists were (of course) protected (HR 0.61 NS overall, preschool 0.48, 95% CI 0.25 to 0.93). There's a hiccup somewhere in this chain. Is the solution the old-fashioned drugs in hand at discharge (TTOs as they were once called), text or more formal reminders for uncollected scripts, or a blunter discussion before going home. *See page 673*

**NETS**

From one imminently treatable chronic disease to another. Despite issues with multidrug resistance, the standard treatment for tuberculosis is long established and largely unchanged over the last generation. Rifampicin is an essential component, dosing set by the WHO and regularly updated (most recently updated in 2014) based on new PK, PD, response and AMR data. For maximum effect (and to prevent resistance) like any other, the peak serum concentration and AUC concentration curve have to be optimal. Tania Thomas and colleagues in Charlottesville, NC, USA and the Haydom Lutheran college and Kilimanjaro Christian Medical College, Tanzania test the validity of urine assay against serum values under directly observed treatment. In short, 34% of children fell short of the appropriate AUC curve, potential reasons being malabsorption (enzyme or villous atrophy), metabolic differences and urinary excretion outside the expected. Unlike their asthmatic counterparts, these children unequivocally took their treatment, a nudge perhaps to individually tailored dosage in the not-too-distant future. *See page 616*

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OK. I'll come clean. Occasionally, I procrastinate. Both editorially and clinically if an acute situation doesn't demand an instant response. There it is, I've said it now: out in the open for all to see. This, though, can be advantageous, so let me add a few lines of defence. This verb (state of being, literally in Latin, to leave until tomorrow) has, rather unfairly found use largely pejoratively. Just think of the euphemisms: 'laboured', 'sluggish', 'blunted', 'lethargic', 'manacled by inertia', and so on... But, I counter parry, these similes do procrastination an injustice. Used correctly (and there to me is *l'arte*) it sometimes just needs a night's sleep. It allows a stocktake, a reconsideration, a refuelling, a more nuanced assessment to make a better decision. So, for all the bravado of the cheetah, don't dismiss the sloth out of hand...

**FLAGS**

It's well known that most children stepping off a long-haul flight from a tropical country with a fever, have a benign, self-limiting, likely viral infection. There is, though, a not infinitesimally small chance that the chance encounter with a parasite-bearing aedes, anopheline, redovid, ixodes, phlebotimine or other potential vector might have led to something a little more 'challenging'. It's no great leap, therefore, to ask whether application of the same red flag approach to children assessed in the PED with unusually long fever irrespective of their recent travel status is reasonable. Ruud Nijman and colleagues at Imperial College, London

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and in multiple European centres assessed the risk in terms of serious bacterial infection in 35 000 children in which fever was part of the symptom complex. Of these, approximately 10% had had fever (defined as a temperature of 38°C at triage or in the previous 72 hours) for >5 days of whom 8.4% had SBI compared with 5.7% in those with shorter duration of illness. Warning signs (respiratory distress, meningal signs, adjusted heart and respiratory rate, altered conscious level had good positive predictive value (and specificities around 0.9) but were not common enough for their absence to robustly rule out SBI. Absence of signs had only a modest LR- ((0.34 (0.22–0.54)) though a low CRP <20 mg/L was reassuring for ruling out SBI (negative LR 0.16 (0.11–0.24). A small, but not insubstantial number (1.7%) had non-infectious causes: Kawasaki, malignancy or rheumatological disease. The paper doesn't (nor does it set out) tell us exactly how to manage this group differently but a low threshold for a blood film and safety netting seems both reasonable and pragmatic. *See page 632*

**SLIPS**

It should be so simple: inhaled steroids (ICS), if taken appropriately (dose, device, frequency), prevent asthma exacerbations and ameliorate interval symptoms. We've known this for around a half century, the all too familiar 'beta-agonist out' phenotype still such a wearily regular acute call and asthma death enquiry feature and yet... Katherine Ya-Hui Chen and colleagues at the Murdoch Children's Research Institute, Parkville, Australia follow-up where work in the US and Italy left off: what happens after an index acute admission. Their analysis, a data linkage study based on close to 800 children, showed that overall, those prescribed an ICS were equally likely to be readmitted within a year. But here's the catch: less than 50%