ARCHIVES OF DISEASE IN CHILDHOOD

The Journal of the British Paediatric Association

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MEETINGS IN 1995

Paediatric Research Society
10–11 February, Liverpool
22–23 September, Exeter
Further details: Dr A Thomson, Leighton Hospital, Crewe, Cheshire CW1 4QJ

Neonatal Society
23 February, Royal Society of Medicine, London
30 June–1 July, Bristol (with the Blair Bell Society)
Further details: Dr Janet M Rennie, Rosie Maternity Hospital, Cambridge CB2 2SW

Global Lessons for Local Problems – What Works in Child Accident and Injury Prevention?
13 March, Belfast
Further details: Mrs Rosie Mercer, Child Accident Pevention Trust, Department of Epidemiology, Mulhouse Building, Grosvenor Road, Belfast BT12 6NJ

Clinical Genetics Society
15 March, Institute of Education, London
Further details: Dr Peter Farndon, Clinical Genetics Unit, Birmingham Maternity Hospital, Edgbaston, Birmingham B15 2TG

1st Congress of the European Paediatric Neurology Society (in conjunction with the 1st Interim Meeting of the European Society for Paediatric Neurosurgery)
19–23 March, Eilat, Israel
Further details: Carmel Organizers of Conferences and Events, PO Box 1912, Ramat Gan 52532, Israel

British Paediatric Association
21–24 March, University of York
Further details: Miss Rosalind Topping, British Paediatric Association, 5 St Andrew's Place, Regent's Park, London NW1 4LB

8th Pediatric Tumours Congress and New Trends in Medicine '95
1–5 May, Adana, Turkey
Further details: Associate Professor Dr Atila Tanyeli, Department of Pediatric Oncology, Çukurova University, Medical Faculty, Adana, Turkey

1st European Congress of Pediatric Surgery
4–6 May, Graz, Austria
Further details: Professor Michael E Höllwarth, Department of Pediatric Surgery, Auenbruggerplatz 34, A-8036, LKH-Graz, Austria

28th Annual Advances and Controversies in Clinical Pediatrics
4–6 May, San Francisco, USA
Further details: Office of Continuing Medical Education, Room MCB-630, Box 0742, University of California, San Francisco, California 94143–0742, USA

4th European Congress of Extracorporeal Life Support
10–12 May, Bergamo, Italy
Further details: Mr Matteo Salvi, ECMO Conference, Centro Congressi Giovanni XXIII, Viale Papa Giovanni XXIII, 106, 24121 Bergamo, Italy

International Symposium on Dyspnoea
22–23 June, University of Amsterdam, The Netherlands
Further details: Simon Rietveld, University of Amsterdam, Room 820, Roetersstraat 15, 1018 WB Amsterdam, The Netherlands

European Society for Pediatric Endocrinology
25–29 June, Heriot Watt University, Edinburgh
Further details: Professor A Aynsley-Green, Institute of Child Health, 30 Guilford Street, London WC1N 1EH

27th British Congress of Obstetrics and Gynaecology
4–7 July, Trinity College, Dublin
Further details: BCOG Secretariat, Congress House, 65 West Drive, Cheam, Sutton, Surrey SM2 7NB

21st International Epilepsy Congress
3–8 September, Sydney, Australia
Further details: Congress Secretariat, Conference Action Pty Ltd, PO Box 1231, North Sydney, 2059, Australia

XXI International Congress of Pediatrics
10–15 September, Cairo, Egypt
Further details: Congress Secretariat, PO Box 161, Magles El Shaab, Cairo (11516), Egypt, or American Academy of Pediatrics, Division of Medical Journals, 741 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927, USA

British Medical Genetics Conference
11–13 September, University of York
Further details: Dr Peter Farndon, Clinical Genetics Unit, Birmingham Maternity Hospital, Edgbaston, Birmingham B15 2TG

European Respiratory Society
16–20 September, Barcelona, Spain
Further details: ERS Central Office, 60 rue de Vaugirard, M5006, Paris, France

7th European Congress on Paediatric, Surgical and Neonatal Intensive Care
25–29 September, Cambridge
Further details: Conference Secretariat, IBC Technical Services Limited, 57–61 Mortimer Street, London W1 7TD

British Association of Perinatal Medicine
29 September, University of Southampton
Further details: Dr Andrew Wilkinson, BAPM, Neonatal Unit, John Radcliffe Hospital, Oxford OX3 9DU

International Symposium: 66 Years of Surfactant Research
5–10 November, University of Vienna/University of Budapest (on board ship along River Danube from Passau via Vienna to Budapest)
Further details: Professor Dr B Lachmann, Department of Anesthesiology, Erasmus University Rotterdam, PO Box 1738, 3000 DR Rotterdam, The Netherlands

INSTRUCTIONS TO AUTHORS

Papers for publication should be sent to the Editors, *Archives of Disease in Childhood*, BMA House, Tavistock Square, London WC1H 9JR. Submission of a paper will be held to imply that it contains original work not being offered elsewhere or published previously. Manuscripts should be prepared in accordance with the Vancouver style.[1] The editors retain the right to shorten the article or make changes to conform with style and to improve clarity.

For guidance on ethical aspects refer to the editorial in this journal.[2] All authors must sign the copyright form after acceptance.

Failure to adhere to any of these instructions may result in delay in processing the manuscript and it may be returned to the authors for correction before being submitted to a referee.

General

- Authors must submit two copies of the manuscript and any subsequent revision.
- When submitting original manuscripts authors should send a copy of any of their other papers on a similar subject to assure the editors that there is no risk of duplicate publication.
- If requested, authors shall produce the data upon which the manuscript is based for examination by the editor.
- Manuscripts must have a title page which gives the title of the paper, the name of the author(s), the place where the work was carried out, and the address of the corresponding author. The number of authors should be kept to a minimum and should include only those who have made a contribution to the research: justification should be made for more than five authors. Acknowledgments should be limited to workers whose courtesy or assistance has extended beyond their paid work, and to supporting organisations. Information about the availability of reprints should be given at the end of the references.
- Authors should provide up to three key words for the index.
- The article and references must be typed in double line spacing throughout with a 5 cm margin on the left side. The right hand margin should not be justified. Pages should be numbered in the top right hand corner.
- All measurements must be in SI units apart from blood pressure measurements, which should be in mm Hg, and drugs in metric units.
- Abbreviations should be used rarely and should be preceded by the words in full before the first appearance.
- In the statistical analysis of data 95% confidence intervals should be used where appropriate.
- Any article may be submitted to outside peer review and for statistical assessment. This usually takes six weeks but a longer period is required for some manuscripts. Articles are usually published within five months of the date of the final acceptance of the manuscript.
- No free reprints will be provided. Reprints may be ordered when the proof is returned; they take about two months to be dispatched and those going overseas are sent by surface mail.
- If the paper is rejected the manuscript and all illustrations will be shredded unless a request is made at the time of submission for their return.

Original articles

- The title should have no more than 10 words and should not include the words 'child', 'children', or 'childhood' (already implicit in the title of the journal).
- The abstract of an experimental or observational study must clearly state in sequence and in not more than 150 words (i) the main purpose of the study, (ii) the essential elements of the design of the study, (iii) the most important results illustrated by numerical data but not p values, and (iv) the implications and relevance of the results. The abstract of a paper which focuses on a case report(s) must summarise the essential descriptive elements of the case(s) and indicate their relevance and importance.
- It has not been the policy of the journal to request structured abstracts. The editors' views were summarised in a previous editorial (Writing economically, March 1990: 251) where we suggested that structured abstracts could be dull to read. We recommended structured *contents* but not structured style of presentation. We are aware, however, that certain research papers *do* lend themselves to a structured style of presentation of the abstract and we now wish to 'test the water'. Some papers will now be published with a structured abstract. If you are submitting a paper and you feel the abstract would be more helpful to readers in a structured style then please submit it in this form.

Short reports

- Length must not exceed 900 words, including an abstract of less than 50 words, one or two small tables or illustrations and up to six references. If more illustrations are required the text must be reduced accordingly.
- The title should be no longer than seven words.

Annotations

- Annotations are commissioned by the editors who welcome suggestions for topics or authors.

Medical audit

Most medical audit is of local interest and for education purposes, however some medical audit may be of wider interest to paediatricians and those involved with developing systems of medical audit. Papers concerned with service evaluation, quality assurance, and outcome measures that may or may not involve medical audit will be accepted and published depending on their merit and relevance. In particular the following may be worthy of publication:

- Models of good practice that include a description of the service before medical audit, the standards developed, a description of the training of professionals to meet those standards, and a demonstration of improvement after medical audit.
- Innovative methods of medical audit.

Letters

- Letters must be typed in double line spacing, should normally be no more than 300 words, have no more than four references, and must be signed by all authors. Two copies should be provided. Letters may be published in a shortened form at the discretion of the editor.

Tables and illustrations

Tables should be presented separately and typed in double line spacing without ruled lines.

- Illustrations should be used only when data cannot be expressed clearly in any other way. When graphs are submitted the numerical data on which they are based should be supplied.
- Illustrations should be trimmed to remove all redundant areas; the top should be marked on the back.
- Patients shown in photographs should have their identity concealed or written consent to publication should be obtained.
- Ultrasound scans, radiographs, etc, should be arrowed on an overlay to indicate areas of interest or should be accompanied by explanatory line drawings.
- If any tables or illustrations submitted have been published elsewhere, written consent to republication should be obtained by the author from the copyright holder (usually the publisher) and the authors. A copy of the letter giving consent must be included.
- Please note that the cost of reproducing any colour figures will be charged to the authors (please contact the editorial office for price).

References

- References must be numbered in the order they appear in the text and include all information (Vancouver style):

  1 Donn SM. Alternatives to ECMO. *Arch Dis Child* 1994; **70:** F81–3.
  2 Hull D. Children's health. In: Smith R, ed. *The health of the nation: the BMJ view.* London: British Medical Journal, 1991: 64–70.

- Abstracts, information from manuscripts not yet accepted, or personal communications may be cited only in the text and not included in the references. References are not checked by us; authors must verify references against the original documents before submitting the article.

1 International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. *BMJ* 1991; **302:** 338–41.
2 Anonymous. Research involving children – ethics, the law, and the climate of opinion. [Editorial.] *Arch Dis Child* 1978; **53:** 441–2.

Manuscript checklist:

- Is the entire manuscript double spaced?
- Is there an abstract?
- Are the references in Vancouver style?
- Are the abbreviations spelt out?
- Are the measurements in SI units?

Revised January 1995

LUCINA

Drug resistant pneumococci were recognised in Europe before they appeared in the United States and it is believed that recent American strains were imported from Europe. Isolates from 13 hospitals in 12 states in 1991–2 were tested (*Journal of the American Medical Association* 1994; **271:** 1831–5) and 16·4% were resistant to at least one commonly used antibiotic (penicillin, cephalosporins, macrolides, trimethoprim/sulphamethoxazole, or chloramphenicol). Penicillin resistance was found in 6·6% of isolates and about 6% were resistant to more than one drug. Resistance to trimethoprim/sulphamethoxazole, erythromycin, or chloramphenicol was more common in children than in adults.

The theory that many of the ill effects of sepsis are caused by the inflammatory response continues to give rise to trials of agents which block the actions of endotoxin or of inflammatory mediators such as tumour necrosis factor (TNF) and interleukin-1 (IL-1). A large multicentre double blind trial of recombinant human IL-1 receptor antagonist in adults with severe sepsis (Journal of the American Medical Association *1994; 271: 1836–43) has shown no overall increase in survival time but retrospectively introduced analyses suggested possible benefits in the most severely ill patients. In an accompanying editorial (pages 1876–8) it is stated that dramatic results from treatment directed against a single mediator are not now to be expected though some benefit may be achieved in selected patients. Combined approaches involving more than one mediator (such as IL-1 and TNF together) are worth studying.*

A report commissioned by the United States Congress (*Journal of the American Medical Association* 1994; **271:** 1602–5) has categorised evidence about adverse effects after immunisation against diphtheria, tetanus, measles, mumps, poliomyelitis, hepatitis B, and *Haemophilus influenzae*. It is considered that a causal relationship is established between: diphtheria and tetanus immunisation and anaphylaxis, measles immunisation and thromocytopenia, anaphylaxis, and severe vaccine strain measles infection (usually in immunocompromised recipients), oral polio vaccine and clinical poliomyelitis, and hepatitis B immunisation and anaphylaxis. Probable causal relationships are judged to exist between: diphtheria and tetanus immunisation and Guillain-Barré syndrome in the immunocompromised, and brachial neuritis, oral polio immunisation and Guillain-Barré syndrome, and immunisation with unconjugated *H influenzae* b vaccine and early onset of *H influenzae* infection. The largest category is of suggested associations where the evidence is inconclusive.

Lucina is always pleased when the findings of studies published in this journal are confirmed by subsequent workers. A study from Denmark (Archives of Disease in Childhood *1993; 68: 352–5) showed a beneficial effect of nebulised budesonide in young children with croup. Now workers in Ontario, Canada have produced similar results in children with less severe croup treated in a children's hospital emergency department* (New England Journal of Medicine *1994; 331: 285–9). In a double blind placebo controlled trial children treated with nebulised budesonide were significantly better than the placebo group on clinical assessment up to four hours later. The treated children were able to go home earlier and fewer of them were given dexamethasone either during the acute episode or in the subsequent week, or sent back for admission to hospital. Nevertheless more than half of those receiving budesonide were given intramuscular dexamethasone at some time. Hospital admission was necessary in one of 27 patients in the treatment group and seven of 27 in the placebo group. Lucina is not fully at ease with the idea of giving children a single treatment dose and then sending them home when they improve.*

Apparently there is in the public mind a notion that homosexuals are more likely than heterosexuals to be responsible for the sexual abuse of children. A study from a special clinic for sexually abused children in Denver, Colorado (*Pediatrics* 1994; **94:** 41–4) has found no evidence to support that idea. Of 269 offenders only two were identified as homosexual. It seems probable that homosexuals are neither more nor less likely to offend in this way. Lucina was never inclined to think otherwise.

Children in Edinburgh suffering from hemiplegic cerebral palsy were given electrical stimulation to the affected anterior tibial muscles applied at home by their parents for one hour each day over five weeks (Developmental Medicine and Child Neurology *1994; 36: 661–73). At the end of the treatment period there was significantly increased passive dorsiflexion at the ankle that was not seen in control children receiving standard physiotherapy. There was no measurable benefit to the children as regards their walking, however, and the authors warn against premature widespread use of the method.*

It has been estimated that parents who smoke add about £143 million to the cost of children's illnesses in England and Wales each year. An editorial in *Thorax* (1994; **49:** 731–4) supplies some disturbing information. Maternal smoking has a much greater effect than paternal, probably most importantly because smoking in pregnancy may cause long term damage to the developing lung. Passive smoking is particularly harmful in atopic families. Maternal smoking increases the risk of fetal and neonatal death by some 30% and approximately doubles the risk of sudden infant death (SIDS). Respiratory illnesses of all kinds, including asthma, are up to twice as common in the children of smoking parents and the effect increases with the number of cigarettes smoked. Secretory otitis media is one third more common if parents smoke. The message seems clear; passive smoking causes mayhem in children.

European seems a reasonable term to apply to the people of this continent but the term Europid does not fall easily on Lucina's ears. It puts her in mind of a set of bones found deep in some alpine crevasse by the likes of Richard Leakey and his pals. Work in Oxford (Journal of Clinical Epidemiology *1994; 47: 837–41) has shown that, when compared with 'Europid' students, Asian students (or should that be Asiad?) have higher serum cholesterol and fasting blood glucose and a different fat distribution. They suggest that this means that the higher incidence of non-insulin-dependent diabetes and of ischaemic heart disease in people of Asian origin may originate in factors present in early life.*

The causes and treatment of infantile colic have been much debated over the years. Treatment with the defoaming agent simethicone (activated dimethicone) has had its advocates but babies in Vermont, North Carolina, and Utah fared no better with this than with placebo (*Pediatrics* 1994; **94:** 29–34).