**Archives this month**

**But who will hold the retractor?**
In the UK, the number of paediatric trainees is strictly (many say too strictly) controlled and NHS hospitals may not afford the luxury of certificated specialists. The government takes a keen interest in the possibilities for transferring clinical tasks to others, especially nurses. US and Australian readers will already be familiar with this process.

A team from Southampton, on England’s south coast, have compared patient “clerking” (obtaining a history and conducting a physical examination) by paediatric surgical trainees and specially trained nurses (page 223). The outcome measure was the safety of children about to undergo day case surgery or minor orthopaedic surgery. On the whole, nurses did a little better than doctors, identifying fewer non-existent concerns and failing to detect abnormalities less often.

Not addressed were issues for paediatrics generally. Experienced clinicians would argue that the first person to take a full history best comprehends the patient’s problems and is most likely to strike up a constructive relationship with the family. If doctors withdraw from this task, are they relegated to mere technicians? And we all know that all sorts of less widely trained (and cheaper) individuals can become technically very proficient indeed.

**AIDS and the new South Africa**
In June, President Mbeki hosted a contentious conference on combating HIV infection. This month (page 227) we reveal the appalling scale of the disaster facing his country. The data come from Zwi and colleagues at Chris Hani Baragwanath Hospital, in greater Johannesburg.

More than 1 in 4 young women attending public antenatal clinics are HIV positive and the vertical transmission rate is 26–42%. The impact on children is massive. In 1992, 9% of children under 15 months admitted and tested proved positive for HIV. By 1996, the proportion was 46%. Over that period, in hospital mortality increased by one fifth, with nearly half those dying having an AIDS related infection. The authors estimate that by the time this paper is published in *ADC*, mortality in children under 5 will have increased by a further 67%.

Bleakly, they state that almost all South Africa’s advances in child mortality since 1960 will have been wiped out.

**Infections (soon?) on the way out**
In the rich world, meanwhile, *Haemophilus influenzae* and *Neisseria meningitidis* group C are in full retreat under the onslaught of immunisation. Consequently, *Streptococcus pneumoniae* and other meningococcal serogroups are of proportionately greater interest. This month, the Oxford pneumococcal surveillance group provide a snapshot of its favourite organism’s behaviour amidst the dreaming spires (page 231). Further north, the meningococcal reference unit publishes details of the value of the polymerase chain reaction (PCR) in identifying its preferred bug (page 271).

The Oxford group found one death in 106 cases investigated. Of the 39 with meningitis, five suffered a sensorineural hearing deficit, two remain on anticonvulsants, and one has a hemiplegia. Five serotypes were responsible for 83% of illness so that the conjugate vaccines currently existing would have covered 92% of isolates. Given the morbidity and cost of disease produced by pneumococci, the authors see their study as a vital early step in planning eventual targeted immunisation.

In Liverpool and Manchester, Carrol and others studied 166 children with a clinical diagnosis of meningococcal disease (“probables”) and 153 who had a petechial or purpuric rash but were neither ill nor shocked (“possibles”). None of the latter had a positive PCR and all were blood culture negative. PCR confirmed more of the “probables” than blood culture. At present, this knowledge may not help clinicians decide when to break out the cefotaxime, but if the logistics can be perfected, a same day result is feasible—but not if the reference lab is inundated with requests to test clinically unlikely cases.

**A nifty “wee” paper**
We publish few case reports but this month we have a cracker” (page 271). Thimm and Coulthard from Newcastle-upon-Tyne had a patient with a duplex kidney, one moiety of which was dysplastic and drained by an unobstructed but dilated pelvis and ureter. At age 2.5 years the patient was still dribbling urine; they suspected that the abnormal ureter was also ectopic, but imaging did not provide an answer.

Therefore, they confirmed their diagnosis by collecting alternately voided specimens and dribbled urine after priming with desmopressin. How? Well, you’ll just have to read the paper to find out.

**FOOTNOTES**

‘obsolete upper class English = smart, clever
"Scots (who are relatively classless) = little
"’UK c1960 = every young paediatrician’s dream

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