Archives this month

A question that regularly crops up at editorial meetings is: "But will it help paediatricians treat their patients more effectively?". The question goes for methodological and laboratory research papers as well as clinical investigations. We can't put hand on heart and admit we always get it right but we do, at least, try—as I hope is evident from some of this month's offerings.

Rings a bell?

We asked Michael Riordan what to do about acute lower motor neurone facial paralysis. He has responded (page 286) by starting with a brief anatomy lesson, followed up by an aetiological list—useful in practice and useful for membership examinees (and examiners if they want to keep one step ahead). He reminds us when to seek specialist advice and what investigations we might reasonably request. Don't forget hypertension. I can't as it was described in the first copy of *ADC* that I ever read[1] and I haven't discovered a case since. Nor should we forget acute leukaemia, sometimes with subtle haematological changes. A meta-analysis of studies in adults supports early use of steroids but evidence is lacking for children. Nearly all recover completely.

1 Lloyd JV, Jewitt DE, Lloyd-Still JD. Facial paralysis in children with hypertension. *Arch Dis Child* 1966;**41**:292–4.

Leaving no stone unturned

Before I went to medical school I was enthralled by tales of nineteenth century surgeons "cutting for the stone" in 30 seconds flat with or without amputating bits of their assistants. Once again, however, this condition is rarely seen by paediatricians in temperate climates. All the more reason, therefore, for commissioning more practical advice, this time from Dr Sally-Anne Hulton, paediatric nephrologist in Birmingham, England (page 320). She confirms the estimated UK annual incidence as 2 per million children. Dr Hulton provides a diagnostic algorithm worth enthusiastic trainees scanning into their palmtops. The critical decision point is to recover a stone and submit it to chemical analysis, which should lead to appropriate—rather than blanket—investigations. In particular, children with recurrent stones, a positive family history or sterile urine deserve metabolic assessment.

New factlets for me were that the second morning urine is best for measuring calcium and magnesium excretion and oxalate does not brook delay.

UTI, VUR, DMSA, and the RCP

The Royal College of Physicians guidelines on management and treatment of urinary tract infection in children are now 10 years old. How do they stand up, especially with regard to the recommendation that children under 1 year should have micturating cystourethrography and those over 7 years should all have a DMSA scan? Deshpande and Verrier Jones were concerned that the guidelines have led to children with trivial illness, treated at home, being unnecessarily subjected to DMSA scanning while many children receive long-term prophylaxis while awaiting imaging, with little or no evidence of benefit (page 324). They audited children seen in their unit at Cardiff; one finding was that only one of 54 children aged 1–6 years treated at home by their GPs developed renal scarring (as opposed to 33% of in-patients). They note that the cost per scar detection in the former was £8040 ($13 000)—money that might be better spent to improve diagnosis and treatment of UTI by general practitioners. They question the benefit of "routine" DMSA scanning, suggesting it might be reasonably limited to those with a history of acute pyelonephritis, frequent recurrence of UTI or delay in diagnosis.

A spoonful of sugar (sorry, sorbitol)

None of us like swallowing bitter pills—children more so. Compliance may be a problem, particularly out of hospital. Lucas-Bouwman and colleagues from The Netherlands compared crushed prednisolone tablets with an oral solution tempered with banana essence, sorbitol and a preservative (page 347). Vomiting was much more of a problem with tablets (9/35 compared with 0/35) and recovery was slower. An extra learning point was that Dutch children eat custard.

Training foster carers

"Looked after" children are likely to have significant medical, developmental, or emotional problems.[2] Minnis and colleagues from Glasgow, Scotland postulated that training foster carers in communication skills and attachment would help the children they care for (page 302). Randomised trials cannot be easy in these circumstances so we are particularly pleased to report their findings, following randomisation of 160 families. The scale of the problem is obvious when one reads that 93% of the children had been abused or neglected previously and 60% had some degree of psychopathology. The trial was a "real-life" one in that training had to be neither expensive nor too time-consuming. The good news was that foster parent participants valued the training and saw it is helpful. Unsurprisingly, however, the authors could find no statistically significant impact on child psychopathology.

They conclude that much more intensive interventions should be considered but recognise that it would require "a major effort of political will and a massive injection of finance", albeit that the latter might be offset against future potential savings. Let us hope that now Scotland has a devolved administration, the authors' hopes might be translated into action.

2 Mather M. Adoption: a forgotten paediatric specialty. *Arch Dis Child* 1999;**81**:492–5.

Another call for covers

Readers tell us they appreciate the illustrations on *ADC*'s front cover. They are not always easy to find and many institutions charge surprisingly high reproduction fees. If you have a good quality image which you think suitable for our cover, please get in touch with the editorial office (email: archdischild@bmjgroup.com).

HARVEY MARCOVITCH

Editor in Chief