Archives this month

At least one medical journal is fond of presenting a "Lesson of the Week". Eschewing such parsimony, this month's ADC overflows with lessons—for example, we must be alert to rare ill effects of common practices (breast feeding and treating asthma with inhaled corticosteroids). The author of an exhaustively researched update on managing non-traumatic coma enjoins us generally to think the unthinkable but specifically to learn an algorithm and a list of vital criteria. Two papers on children with complex health needs detail how we fail them and, refreshingly, what might be done about it. The most fascinating lesson of the month, for an editor who likes words such as eschewing and parsimony, is a study from Kenya which provides evidence of the sensitivity of linguistics in making a bacteriological diagnosis. Tempted? Then read on.

Priorities in treating coma

Neurologist Fenella Kirkham aims a major review at those whom she calls "the worried paediatrician in casualty [emergency room] or in the ward faced with a child in non-traumatic coma who may need intensive care" (page 303). Such patients should benefit if her advice is followed. In our increasingly judgemental and litigious society, paediatricians too might benefit from pinning it up on the departmental noticeboard and providing summaries of its tables for their trainees. The author asks readers to err on the side of caution by being pessimistic with the initial Glasgow or James score and by assuming intracranial hypertension rather than spending too much time trying to exclude it.

Watch out for wheezers

Inhaled corticosteroids have revolutionised the lives of millions of asthmatics, including me. So it is a little alarming to read Patel and colleagues' description of 8 children with *symptomatic* adrenal insufficiency while taking doses most of us would regard as reasonable (page 330). They point out that this has not been described previously, although we are familiar with biochemical evidence of pituitry-adrenal suppression, minor degrees of growth faltering and occasional Cushingoid phenomena. Alarmingly, two of these children presented with acute hypoglycaemia. The others presented with poor weight gain and/or growth and, in one case, with headaches. The authors do not draw any conclusions from the fact that only one of the children was taking the "first-generation" inhaled steroid most commonly prescribed in the UK—the numbers are too small for them to do so with any degree of confidence. Nonetheless, prescribers might reasonably respond by stepping down the steroid dose whenever it is safe to do so and by reminding themselves of the roles of leukotriene receptor antagonists and long acting beta-adrenergic agents in helping them achieve this goal.

Breast is best, but not invariably

Another pitfall for paediatricians is the infant admitted with weight loss, dehydration and hypernatraemia. A population study from the Northern region of England identified eight such babies which the authors extrapolate to an incidence of just over two per 1000 breast feeding primiparous mothers (page 318). All were admitted at 6–10 days old, having lost over 15% of their birthweight, and had serum sodiums between 150 and 175 mmol/l. No baby turned out to have an underlying metabolic disorder and all survived, although one had fits.

Their clinical characteristics are described in the paper along with advice on management (be alert to the diagnosis but slow in correcting the biochemistry). A telling observation is the authors' experience of resistance by midwives (responsible for the care of newborns for their first ten days in the UK) to weighing breast fed babies in case revelation of weight loss provokes a mother into changing to formula feeds. They recommend adoption of the contrary practice recommended by the American Academy of Pediatrics.[1]

1 American Academy of Pediatrics. Breastfeeding and the use of human milk. *Pediatrics* 1997;**100**:1035–9.

Mobilising children with cerebral palsy—a postcode lottery?

The NHS should be ashamed of the lack of resources available to help children with cerebral palsy. In their Current Topic, a team from a specialist unit review various tried, but did not always test, interventions which are still used (page 275). They emphasis the prime importance in planning therapy of techniques such as gait analysis, video filming, dynamic electromyography, and assessing the energy cost of walking. They point out the inadequacy of many historically accepted surgical approaches and highlight the European/North American split on the value of selective dorsal rhizotomy. They provide a concise overview of using botulinum toxin and (I suspect) introduce many paediatricians to the potential of intrathecal baclofen. Their paper is littered with reminders of the poor evidence base for much that is done and the "postcode lottery" of what treatment is offered—surely something for the newly appointed Children's Commissioner to get his teeth into.

More unmet healthcare needs

Another deprived group is children in the care of local authority social service departments. What the authors describe as a unique case control study from Wales (page 280) shows the relatively good physical health of these children, attributed to high quality regular medical checks. But it also reveals the extent of problems related to emotional state, behaviour, and health promotion. Of 64 young persons (more than half those surveyed) requiring involvement from child and adolescent mental health services, 34 were on a waiting list when interviewed, compared with five and three controls respectively. National Assembly for Wales, please note.

Culture: societal or bacteriological?

Finally, a fascinating study of solar disinfection of drinking water in Kenya reveals a startling statistic (page 293). Linguistics alone are highly sensitive in diagnosing infection with *Vibrio cholerae*. Another triumph for history taking—provided it is done properly.

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