Improved outlook for meningococcaemia

About two years ago we published a paper from the paediatric intensive care unit at St Mary's Hospital, London on managing meningococcal disease. It detailed the authors' personal practice, a type of paper going out of fashion in these days of systematic reviews and meta-analyses. Our unfashionable behaviour was provoked by requests from paediatricians to help them cope with this dangerous condition. This month we report on whether the ends have justified the means. The St. Mary's group present an outcome audit comparing case fatality in 1997 with that of 1992 (page 386). Their paper follows a similar evaluation, from the Royal Liverpool Children's Hospital covering the period 1995–98 (page 382).

Both groups have used the paediatric risk of mortality score (PRISM) as a benchmark. Their results are encouraging. In these days of media inspired doctor bashing (surely not confined to the UK?) their results should be trumpeted abroad. The case fatality rate at St. Mary's fell from 29% to 2% over the five years of their audit, despite no evidence of a change in severity of presenting illness. That from Liverpool averaged 8.9% over the full 38 months of their data collection. The weaknesses of PRISM are discussed—in particular the view that it may now overestimate likely mortality. Both groups ascribe improvements to better management at referral hospitals and accident and emergency departments, more sophisticated retrieval facilities, centralisation of care and advances in intensive care practice.

ADC would like to think that breaking its rules in 1999 has helped the process along, but we make no guarantee to offer the same dispensation for other clinical situations.

Prevention is better than cure

Meanwhile, at least meningococcal C infection is retreating in response to vaccination programmes. In the UK, universal primary immunisation against this organism started in November 1999. Many of our readers thought the Department of Health and NHS Executive had acted with commendable, albeit uncharacteristic, speed in response to vaccination programmes. In the UK, universal primary immunisation against this organism started in November 1999. Many of our readers thought the Department of Health and NHS Executive had acted with commendable, albeit uncharacteristic, speed in response to vaccination programmes.

This month, the Sheffield Institute for Vaccine Studies, the Scottish Centre for Infection and Environmental Health and the manufacturers of the Chiron Men C vaccine, report an open label safety study which looked at over 2700 infants receiving the primary vaccine course during 1998–2000 (page 391). The authors claim a study power capable of a 94% chance of detecting at least one uncommon adverse event and a 24% chance of observing at least one rare event.

The vaccine definitely caused five events (local injection site reactions) and probably caused five others—agitation, rash and fever. A further 48 minor adverse events were possibly related, while 1755 were considered irrelevant to the vaccine. The four events designated as serious (hypotonia, screaming, rash and agitation) were regarded only as possibly vaccine related.

Respectable, moi?

Responding to our editorials on the report into retained organs, one of our correspondents, Dr Scammell, points out that respected scientific journals do not normally indulge in political issues (page 000). I am not sure whether to be pleased or sorry to tell him that the next issue of the Journal of Clinical Pathology will be editorialising at even greater length than ourselves. Further, riffing through my accumulated piles of the BMJ and JAMA leads me to one only possible conclusion: they just can't be respectable. Teasing aside, Dr Scammell has hit on a crucial area for the future of scientific journals in general, let alone ADC in particular. Most journal editors believe that, with the growth of virtual publishing, more and more original studies will appear on centralised websites such as BioMed-Central. Once academic institutions lose their inhibitions about recognising cyberspace when calculating brownie points (or impact factors as they like to think of them), specialist journals such as ADC might find themselves starved of contributions. We may well have no choice but to respond by actually giving readers what surveys tell us they want—namely more reviews, editorials, abstracts, distance learning, and so on—what a magazine editor would call "features". And politics are bound to come into the equation. My successor as Editor in Chief, due in post during 2002, faces interesting times.

How hard is soft?

Some patient pressure groups prefer to maintain the largely artificial dichotomy between "organic" and psychosomatic disorders. In pleading that their particular illness must have an "organic" origin, they often set great store by the presence of soft neurological signs—transient weakness here, asymmetric tendon reflexes there, mirror movements everywhere.

They will be disappointed to read Fellick and colleagues' review of 169 children in mainstream school, whom they tested for a battery of these signs (page 370). They found 18 who had major abnormalities of such subtleties as stereognosis, graphaesthesia, dysdiadochokinesis, and mirror and involuntary movements. Children with a "high soft sign score" were more likely to be cognitively impaired, have behaviour disorders such as ADHD, or lack coordination. The authors concluded that seeking (and finding) soft signs gave little information to guide management of these children.

Editor in Chief

HARVEY MARCOVITCH

Editor in Chief
