This month’s innovations
There are several firsts this month. We republish an editorial which first appeared in the October issue of British Journal of Ophthalmology (page 452). The BMJ group produces more than 20 specialist journals. They contain a mine of information which few of us have time to access—a wasted resource. Consequently, a syndications editor has been appointed to scan these journals and recommend to his colleagues papers they might wish to republish in full or in part. So far as ADC is concerned, the aim is to draw our readers’ attention to important papers they might not otherwise know about.

Secondly, after much deliberation, we are publishing interview material obtained from a convicted child murderer (page 454). Our motive is not prurience; we believe the perpetrator’s words illuminate startlingly the fact that someone can kill their child yet still express intense feelings of attachment and grief. Paediatricians, police officers, the judiciary, and social workers have long been aware of this paradox. However, many doctors who are not clinicians, administrators, politicians, and those in the media are not, to the extent that they may be fooled into distrust of the “whistleblower”, and assume that the perpetrator is innocent and the professionals guilty.

Thirdly, December is gloomy in the northern hemisphere but Christmas is festive, so we have published a selection of quirky, unusual, or plain dotty contributions—including that the first ever play published in a scientific journal (I think) (page 494).

Vigabatrin—do the eyes have it?
Vigabatrin is recommended for treating infantile spasms and as add-on therapy for partial seizures. Prescribers and parents are rightly anxious about the risk of retinal dysfunction with this drug, a risk not yet defined with sufficient precision. Koul and colleagues from Oman have followed up 21 of 29 children, who took Vigabatrin for more than 6 months (page 469). One child suffered optic atrophy, three others developed significant eye changes, and 14 developed abnormal visually evoked potentials (VEP). The authors recommend that the drug can be used, but with due caution, guided by baseline VEP, repeated eye examinations and 3–6 monthly electroretinography.

The cost of respiratory syncytial virus infection
Last year we published information which we hoped would help paediatricians decide whether and whom to treat with prophylactic palivizumab. The ensuing debate provided heat as well as some light. One criticism of those studies was that their cost-benefit analyses did not take into account the costs of any long term sequelae. This month, paediatricians from a number of UK hospitals have joined with researchers from Abbott laboratories to compare the use of health care resources by infants with chronic lung disease of prematurity, according to whether or not they had been admitted to hospital with proven RSV infection (page 463).

The authors calculate the total health care costs, for a baby born at a mean gestation of 27 weeks with CLD and proven RSV infection during their first two years of life, as £12,638. (US$ 19,000). This compares with about half that amount if admitted with probable bronchiolitis (RSV unproven) or with other respiratory illnesses. Babies who were not hospitalised with a respiratory illness cost a mean of £2461 (US$ 3700). The authors’ key message is that RSV infection carries a significant financial burden in babies with CLD. Our deputy editor, Dr George Russell, a respiratory paediatrician, commentates (page 468), concluding that he would rather prescribe a drug because it would help his patient than because it saved (or, presumably cost) a few pounds. The paper is too late to influence the 2000–01 RSV epidemic but we await, with interest, to see if it provokes doctors to change practice for 2001–02.

Treating pain when the child can’t ask
Over the years, paediatricians and paediatric nurses have scarcely covered themselves in glory when dealing with children in pain. One group, especially disadvantaged, is children who are cognitively impaired to the extent that they have no expressive language. They rely on their parents or other carers to interpret their distress to those who should have the ability to offer relief. Thirty-four parents in Bath, England, reported their perceptions of their children’s pain over a two week period (page 460). Pain was common: only 9 children being assessed as pain free. Two-thirds were thought to have periods of moderate or severe pain. Shamefully (although the authors do not use the word) none was being treated specifically with pain relief. The authors recognise an urgent need to develop methods of recognising when such children are in pain, which can be used in routine practice and lead to effective management.

ADC blows its own trumpet (with mute)
Dr Vargas-Origel and others from Mexico decided to use a bit of scarce relaxation time with a bit of journalology (page 497). They counted up errors in the published references in papers published in four international paediatric journals, including ADC. Far be it from us to crow when 22% of our references contained errors. But only 1 error was a technical editor’s hanging offence and our rivals made much more of a hash of things, Pediatrics taking the booby prize. Who said we are reluctant to publish papers with negative results?