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The editors will decide, as before, whether to also publish it in a future paper issue.

LETTERS

Calibration of the paediatric index of mortality in UK paediatric intensive care units

Pearson et al should be congratulated on successfully collecting the data required for calculating the PIM Score on 7235 children admitted to 5 UK paediatric intensive care units (PICUs).1 It is reassuring to note that the authors did not find any systematic differences between these five units in terms of their standardised mortality ratios. Leaving aside the controversies involved in cross country comparisons, it is further pleasing that they appear to conclude that mortality following admission for paediatric intensive care in 1999 was less than it was in 1994–95.1 The current results imply that 78 more children have survived following treatment in these 5 PICUs than were predicted by the 1994–99 PIM derivation model.

Before this can be considered a major clinical advance, it is important to consider the health status of the additional survivors. Very different conclusions might be drawn if the additional children who survived have a very poor health status than if they have a very good health status.

The United Kingdom Paediatric Intensive Care Outcome Study (UK PICOS) was set up in response to the “Paediatric Intensive Care: A framework for the future” document and a joint United Kingdom Medical Research Council and Department of Health working paper.2 Both these publications recognised that, as mortality following paediatric intensive care is less than 10%, morbidity or health status may be a more important outcome of paediatric intensive care than mortality. UK PICOS is currently collecting health status measurements of children who survive following admission for paediatric intensive care in a representative sample of 21 UK PICUs. By seeking to differentiate between the survivors of paediatric intensive care, UK PICOS may lead to a risk adjustment method for health status in addition to mortality. Furthermore, UK PICOS has the potential to provide the methodology to enable cost effectiveness studies to be set up in paediatric intensive care. In the longer term this will allow organisational structures, service management, and new interventions in paediatric intensive care to be evaluated in a more rigorous manner than at present. Further details of UK PICOS are available at www.shef.ac.uk/~scharf/ukpicos.

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References
5 MRC/DoH Working Party on Intensive Care: The research needs and opportunities relevant to the NHS Medical Research Council 1997.

Calibration of the paediatric index of mortality score for UK paediatric intensive care

Pearson and colleagues have presented data highlighting the use of the paediatric index of mortality (PIM) score as a tool for auditing paediatric intensive care unit (PICU) performance.3 Whilst we would agree with the authors’ message that PIM has many advantages over other scoring systems, we feel that urgent calibration is needed before this tool is adopted as a benchmark for performance indication in the UK. PIM variables were developed predominantly from an Australian data set (one British PICU, Birmingham participated) over 1994–95; the data used in Pearson’s validation comes from five UK PICUs, including our own over the period 1998–99. PIM continues to discriminate between death and survival reasonably well giving an area under the ROC curve of 0.840 (95% CI 0.819–0.853), marginally less than the figure of 0.90 seen in the original paper.4 However, from the 4 year period between development and validation the model is now calibrating poorly, as evidenced by two pieces of information from Pearson’s study.

First, the overall standardised mortality ratio (SMR) is 0.87 (95% CI 0.81–0.94); this figure is remarkably concordant across 4 of the 5 PICUs. Second, from table 2, it is possible to calculate the Hosmer-Lemeshow statistic: chi-squared = 37.41, p<0.0001. This implies poor calibration, (good calibration traditionally represented by a p value >0.10).

The reasons for the loss of calibration are unclear. A possible, perhaps over optimistic explanation is that UK units in the latter study were all “over performing” given that individual units demonstrated an SMR of between 0.83 and 0.89. However, it is unlikely that such a quantum leap in the quality of paediatric intensive care delivery has occurred over the 4 years between 1994–98, given that no major treatment breakthroughs or radical service reorganisation has occurred in this time.

More recent data from our PICU highlight the trend towards poorer calibration, where the PIM-derived SMR from 910 patients seen during the 2000 calendar year is 0.54 (95% CI 0.39–0.69). The authors acknowledge the shortcomings and state that a revised version of PIM will soon be available. However, recalibration is only worthwhile if a very broad sample of UK units participates. The UK PICOS study (paediatric intensive care outcome study) will attempt to address this, by collecting data used in the calibration of several scoring systems across the whole of the UK over a one year period commencing March 2001. From this study it is hoped that an optimal indicator of PICU performance will be derived.

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References

Authors’ reply

Dr Tibby and Dr Murdoch note that, in our study of paediatric intensive care units (PICUs) in the UK,5 PIM discriminated well between children who died and children who survived, with an area under the ROC curve of 0.84. However, they are concerned that PIM had “poor calibration” because the standardised mortality rate (SMR) in the UK units was 0.87 (95% CI 0.81–0.94)—that is, the actual number of deaths was only 87% of the number predicted by PIM. In fact, this figure is almost identical to the PIM SMR for all PICUs in Australia in 1997–99, where the SMR was also 0.87 (95% CI 0.81–0.92). It is very encouraging that PIM gives such similar results in Australia and the leading PICUs in the UK, as it suggests that standards are comparable between the two groups of units and that PIM performs similarly in Australian and UK children.

It is normal for SMRs to fall with time as intensive care improves, and for mortality prediction models to need recalibration. This has happened with PRISM,6 MP7 and APACHE,7 as well as PIM. Despite Dr Tibby and Dr Murdoch’s reservations, the fact that the SMR has fallen even to a similar amount in both Australia and the UK suggests that standards of care have improved in PICUs in those countries in recent years.

Dr Tibby and Dr Murdoch point out that the Hosmer-Lemeshow test gives a low p value for
PIM's performance in the UK data. This test divides the sample into 10 groups, ranging from very low to very high risk of death, and compares the actual number of survivors and non-survivors in each group with the number predicted by PIM. Because PIM predicts too many deaths in the leading units in the UK, it follows that the number of actual deaths differs from the number predicted—so the Hosmer-Lemeshow p value is low. However, table 2 in our paper shows that the ratio of observed to expected deaths was similar across the 10 groups, so that the recalibrated model is likely to fit well. The fact that the Hosmer-Lemeshow test gives a low p value does not necessarily mean that a model (such as PIM) is invalid—it often means only that the standard of care in the test PICUs differs from that in the units in which the model was derived.

The PICUs that contributed the data from which the PIM score was derived were all leading units that deliver a high standard of care, so the score reflects best practice in 1994–96 when the data were collected. We are recalibrating PIM using data from units in the UK and Australia, and the new model will be available this year. Unfortunately, the quality of paediatric intensive care is not uniform in the UK and Australia, and the new model will be leading units that deliver a high standard of care, which the PIM score was derived were all groups from the whole of the UK (PICOS). The UK should aim for best practice rather than being content with average practice.

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Table 1
Lung function data: simple spirometry after bronchodilator inhalation

<table>
<thead>
<tr>
<th>Case</th>
<th>FEV1 (% of predicted)</th>
<th>FVC (% of predicted)</th>
<th>Number of years followed up</th>
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<tbody>
<tr>
<td>Preop</td>
<td>Postop</td>
<td>Long term follow up</td>
<td>Preop</td>
</tr>
<tr>
<td>1</td>
<td>60</td>
<td>75</td>
<td>76</td>
</tr>
<tr>
<td>2</td>
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Table 2
Chest x ray score

<table>
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<tr>
<th>Case</th>
<th>Operation</th>
<th>Local Chrispin-Norman scores</th>
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<th>Postop</th>
<th>Long term follow up</th>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>2</td>
<td>RUL</td>
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</tr>
<tr>
<td>6</td>
<td>RLL and RML</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Data are the Chrispin-Norman scores in the lung quadrant within which the patients had developed focal bronchiectasis and for which they underwent lobectomy (maximum score 8).

References

Long term results of lung resection in cystic fibrosis patients with localised lung disease

We have previously reported favourable short term outcomes following lobectomy in six children with cystic fibrosis and severe localised bronchiectasis (range 6 months to 6 years post-operation). Prior to surgery all had significant respiratory symptoms despite aggressive conventional treatment, including frequent courses of intravenous antibiotics. One child remains better after surgery, but has recently required increased intervention to maintain wellbeing (case 5). Two children require antibiotics as frequently as prior to surgery with chronic signs (cases 3 and 6). There were no precipitating risk factors predictive of a less favourable outcome in these patients. Lung function has been maintained in all except one case (case 6).

Follow up chest x rays were assessed by a consultant paediatric radiologist, using the Chrispin Norman Scoring system. New radiological changes have tended to occur in the zones previously occupied by the resected lobe (table 1). One of the patients has had a bronchoscopy following right upper lobectomy (case 3). Upwards displacement of the right middle lobe bronchus appeared to be causing airway narrowing. Such distortion of the lung anatomy may predispose to bronchiectasis in lobes that have shifted to occupy the spaces previously occupied by the resected lobe.

Our long term results suggest that surgical resection is a worthwhile option in selected children with severe localised symptomatic bronchiectasis. Detailed preoperative assessment is essential to exclude patients with more extensive lung damage. While there is a good long term improvement of symptoms and preservation of lung function in the majority of patients, there is a tendency for new radiological abnormalities to occur in the zones previously occupied by resected lobes.

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Anti-neutrophil cytoplasmic autoantibody positive glomerulonephritis in monoyzygotic twins

Scanty information is available concerning anti-neutrophil cytoplasmic autoantibodies (ANCAs) associated disease in children, and very few cases of familial vasculitis have been reported in the literature.1,2

We have observed two monoyzygotic twins developing ANCA necrotising glomerulonephritis (GN). A 7 year old boy was hospitalised for normocomplementemic acute nephritis. Percutaneous renal biopsy revealed idiopathic crescentic GN with negative immunofluorescence. Dialysis was started because of evening in renal insufficiency. Despite several courses of daily plasma exchanges combined with intravenous methylprednisolone and cyclophosphamide, there was no improvement; one year later, the boy received a cadaveric renal transplant.
 Persistent proteinuria appeared four years after transplantation, when a renal biopsy revealed focal necrotising GN.

 At the age of 10 years, the identical male twin was found to have microscopic haematuria and proteinuria of >1 g/24 h with normal renal function. Renal biopsy showed focal necrotising GN with 20% cellular and segmental crescents. Perinuclear ANCA were observed at a dilution of 1/160. The stored samples of the first twin were tested and pANCA were detected by indirect immunofluorescence.

 This second twin was given intravenous methylprednisolone and cyclophosphamide. The clinical picture was characterised by acute episodes resolving with repeated courses of methylprednisolone pulses.

 ANCA positivity in the second twin (also found retrospectively in the first twin’s serum) allowed us to classify the disease as a renal limited vasculitis expressed by necrotising and crescentic GN.

 The HLA antigen profiles of the two boys are A31,11; B27,35; DR12; DQ1. Acute nephritis or urinary abnormalities were the initial onset symptoms in our patients. They occur in about 40% of children with ANCA associated GN.6 This emphasises the need for a precise diagnosis and aggressive treatment in such patients. ANCA should be sought in the presence of acute nephritis or persistent urinary abnormalities of unclear aetiology, and not only in children with frank vasculitis or rapidly progressive GN.

 We believe this to be the first report of the recurrence of paucimmune crescentic GN in a transplanted kidney in a child. Anti-rejection treatment with steroids and cyclosporine A seems to be a useful means of controlling disease flares up.

 Furthermore, as far as we are aware, this is the first report of pANCA GN in HLA-identical twins. The pathogenesis of ANCA-GN is unknown but likely implicates genetic and/or environmental influences.7

 The onset of disease at different times in two identical twins seems to suggest a genetically determined susceptibility rather than environmental triggers. Review of the literature revealed few reports of familial vasculitis, with some evidence suggesting a genetic predisposition of the HLA class I antigens present in our twins (A11, B35), and antigen B35 alone have also been found in two patients.8

 In conclusion, a pANCA test should always be performed in children with acute nephritis of unclear aetiology; a diagnosis of ANCA GN should not prejudice renal transplantation. HLA B35 may play a role in the pathogenesis of ANCA GN.

 References

Treating childhood hyperhidrosis with botulinum toxin type A

Recently there have been a number of published studies on the use of botulinum toxin type A for hyperhidrosis.1 These studies focus on its use in adults and we would like to highlight that it can also be useful in treating childhood hyperhidrosis. As in adults, hyperhidrosis can have considerable impact on quality of life in children. This is illustrated by a 13 year old healthy girl referred for treatment of axillary hyperhidrosis. Excessive palmar sweating caused difficulty with school work (difficulty holding a pen, with the ink smudging the paper because of sweating) and social embarrassment. Botulinum toxin type A (Dysport; 20 mouse units) was administered intradermally using a 27G needle to the finger tips and the area over the hypothenar and thenar eminences of both hands. EMLA cream was used for topical anaesthesia. She reported sufficient reduction in palmar sweating within one week to improve her school work. She noticed grip strength reduction that lasted three weeks but did not affect hand function significantly. The beneficial effect of botulinum toxin lasted four months after which she requested further treatment. Repeat injections were given to the fingertips only. No adverse effect on grip strength was reported despite some functional benefit from reduced sweating. To date she has had four courses of treatment over a period of two years with good effect.

If you would like to buy a gentle gift for a literary medical friend, you could do worse than this lighthearted escapade, all royalties from which are paid to the Royal Medical Benevolent Fund.

The editor, Dr Saleem Goolamali, has persuaded various of the great, good (and Lord Archer) to provide an anecdot or two, often with a medical reference. Sir Edward Heaf professes his love of American football, Rabbi Lionel Blue provides a recipe which will please encyclopediologists everywhere and a recently retired Regius Professor reminisces on how fate might have led him to be a ballet dancer instead. Would Covent Garden’s gain have balanced Oxford’s loss? Lord Archer relates a childhood memory which might well be true.

You won’t split your sides but there are plenty of chuckles—and the RMBF is well worth supporting in its aim to provide help for doctors or their families who have fallen on hard times. You can order a copy from MediDerm, 25 Highfield Road, Northwood, HA6 1EU, UK.

H Marcovitch

Caring for Muslim Patients


Islam is the religion of one-fifth of humanity and, with an estimated population of 1.6 million Muslims form Britain’s largest religious minority group. There is, therefore, a need for a book that gives advice and guidance to non-Muslim healthcare professionals when dealing with Muslim patients and their families which is what this publication is trying to do. It is divided into nine chapters, peppered with anecdotes and examples, with a summary box at the end of chapters, and concludes with useful appendices on Islam and the Internet, Muslim organisations, and a glossary.

Following an overview of Islam and Muslims in Europe, it delves into issues that are important in the daily life of a Muslim family—like birth, marriage, and death as well as health matters at times like the fasting month of Ramadan and pilgrimage to Mecca. Chapters on Fasting and Pilgrimage may not be of direct interest to the paediatrician but remembering the holy days in the Islamic calendar may improve, among other things, clinical attendance.

The chapter on birth customs is probably what that black string around the infant’s foot (Kabah or Umbilical Cord) to believe them to be a religious command. Muslim myself, I may not agree with some statements made by the authors; in particular, the suggestion that respect, would be an invaluable reference. This is an interesting book which I very much enjoyed reading. If its aim was to provide information, it has succeeded. I feel, however, that it should not be used as a religious reference by health professionals to make decisions or give advice, to avoid contradicting the teachings of Islam. As a Muslim myself, I may not agree with some statements in the book nor wish my patients to believe them to be a religious command. Islam has no saviours or messiahs not to use their inhalers—corticosteroids during fasting (in case of the inhaled medication enters the oesophagus) is an example. Some statements made by the authors are based on cultural practices rather than religious facts. These practices may have developed over centuries, specific to a particular Islamic society and as an Arab, some customs described in the book are as unfamiliar to me as they would be to a non-Muslim. This book tells us a lot about customs and practices in Muslims of Asian roots and in that respect, would be an invaluable reference.

R Tawfik

The Child with Headache: diagnosis and treatment


Over the past 10–15 years there has been a large volume of research into headache, in general, and childhood headache in particular. Research interest and publications have covered vast areas of previously neglected aspects of childhood headache including epidemiology, pathogenesis, clinical features, classification, impact on child’s life and education, management, psychological adjustment, and medical treatment. Two major developments have helped to drive research into childhood headache and migraine. Firstly, the publication of the classification and diagnostic criteria for headache disorders, cranial neuralgias, and facial pain by the International Headache Society in 1988 triggered better understanding, research interest and debate into headache. Secondly, the introduction of a new generation of specific anti-migraine medications in the early 1990s has started a huge wave of research into migraine. Sumatriptan was the first of many 5HT1 agonists to show effective relief of migraine headache in adults associated with

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References


BOOK REVIEWS

Twice Daily After Meals


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References


high expectation for a strong potential in children. The two factors drive research into childhood migraine many steps forwards. Unfortunately despite the huge amount of new knowledge on the subject and, possibly, the increased prevalence of headache and migraine in children, there is more need now than ever for an up-to-date publication on the subject. Until now, only two books on childhood headache and migraine are available on the paediatric shelf. The Classical books of Charles Barlow (Headache and migraine in childhood, Oxford: Blackwell Scientific, 1984) and that of Judith Hackney and Laurence Wallis (Migraine in childhood, London: Butterworth, 1988) remained the most recent sources of information and advice for practising paediatricians and general practitioners. Therefore, this book comes at an appropriate time to fill some of the gaps in the paediatric literature.

The book deals mainly with the diagnostic issues, differential diagnosis, and the management of childhood headache in a simple and practical way. Complex concepts and mechanisms were introduced and discussed with simplicity that made the reading of the book flow easily. Headache was introduced as a pain syndrome that has its own methods of measurement and management in the early part of the book. The general direction of the book was determined, therefore, by the fact that 7 out of the 10 contributing authors been pain scientists, clinical psychologists, or child psychiatrists. Such an influence towards the psychology of pain has enhanced the quality of the book and enriched its value and contents. Therefore, the book provides the researcher on the subject of pain and headache a valuable reference to understand difficult issues in relation to pain measurement, impact of pain and headache on child’s life and also the management of headache including the management and treatment of headache.

From the point of view of the practising general paediatricians who deal with children with headache in busy medical paediatric clinics, the book provides a good brief overview of the causes of headache, diagnostic assessment, and treatment. The use of simple data collection sheet would be very useful to assist the attending physician in establishing the diagnosis of the type of headache and also in identifying both the trigger and relieving factors. The editors propose, in two appendices, lengthy interviews of the author and the parents that may defy the practicability of the consultation. It would be more appropriate to the clinician if those interviews were short and direct. Also, diaries would be a useful tool to help understand the child’s headache by recording symptoms as they occur.

There is no doubt that this book will prove to be an important and useful resource for paediatricians treating children with headache. Other publications dealing with the practical issues and the organisation of headache for children are also needed.

Abu-Arafeh

Core Paediatrics and Child Health


Another textbook of paediatrics finds its way to market, to take its place alongside those already in print. In their introduction, Haddad et al write that they have written this for undergraduates and junior doctors undertaking their first paediatric post. The underlying concepts arise from prior collaborative work undertaken by departments of Child Health in Scottish Universities in response to the GMC guidelines contained in “Tomorrow’s Doctor”. This work, reported in Medical Education,1 provides a structure that gives uniformity of approach for each organ system and indeed the textbook is clearly and consistently laid out.

As with many other authors of textbooks, the authors start with an assumption that the layout of texts will influence learning. It is difficult to find any supportive evidence in educational literature and any research suggests that it is assessment rather than the format of the text that drives acquisition of knowledge and reasoning skills.2 Nevertheless it seems reasonable to assume that those learning paediatrics should be able to choose from a selection of texts written and laid out differently. As such, it could be commended to students if they are considering the purchase of a textbook to support their learning, and I feel sure it will take its place in the “top five” of UK paediatric textbooks.

Although system based, the authors claim that this is a “problem oriented approach”. This does not match other books that start with clinical signs and symptoms; such a true problem oriented approach can be seen in Field et al’s book. This difference highlights the difficulty of writing a text for both students and practising doctors. Anecdotally, students, who seem to prefer topic based teaching while SHOs, may find a true problem based approach more suited to their needs. They do, nevertheless, include “key problems”, and have useful sections that review underpinning science, such as “Essential background”. For the enthusiastic student who wishes to pursue any topic further, they have included “Beyond core” material and sections entitled “Highlights and hypotheses”.

At over 300 pages, it probably contains more than is needed at undergraduate level but could be seen as core and a suitable text for reference. SHOs might find its system based layout less helpful in their learning how to practice paediatrics, but it would be a useful starting point for revision for postgraduate exams.

Teachers need to look at evaluation from a different perspective. How would they evaluate material for students undertaking their course? Fundamentally, any text should support and NOT divert student effort from the learning objectives of the course and help the teachers by providing them an agreed core curriculum. As a collaboration between Scottish departments of paediatrics, this should not present a problem north of the border, but others will need to analyse it mindful of their own course objectives. As a tutor at Imperial College School of Medicine this would raise problems. Our main course objectives are that:

1. Students should acquire understanding of families, their structure and how children are supported within this.
2. Students should acquire the skills of history taking and examination of children along with the necessary communication skills.
3. Students should acquire a basic knowledge of common and important childhood diseases.

This textbook clearly supports the last objective but neither 1 nor 2, although it is only fair to say that this criticism could be levelled against other similar textbooks. This could be seen as an argument for radical redesign of all undergraduate texts to match the more fundamental course aims rather than a “topic based” core curriculum, but such discussion is outside the remit of a book review such as this.

My one major criticism is that it divides up history taking and examination according to body systems. Development of these clinical skills must be the cornerstone of undergraduate education, and dissection of history taking and examination makes it a difficult text from which to teach these essential practical skills. Having said that, this book offers a fresh, innovative problem based medical school approach. It is not part of a core curriculum in paediatrics.

M D C Donaldson

References


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