



## A LOUDER VOICE FOR CHILDREN

Editors are pleased when authors use language precisely. It is not a question of pedantry but rather the knowledge that sloppy language frequently implies sloppy science. In her leading article, Elspeth Webb rightly ignores the ugly neologism “advocating” and, uses “advocacy” according to its true meaning.

It matters: as she points out, local authorities and voluntary agencies (and, dare we point out, not a few paediatricians) falsely define advocacy as enabling children to speak for themselves. Those of us who have given evidence in Court know well that advocates—whether for or against us—provide pleas and intercession rather than empowerment.

Webb enjoins paediatricians to encourage patients and families in self-advocacy, a quite different concept, and exhorts us to regain our traditional key role as advocates for the needs of children, which has become unfashionable in the decade of consumer power and suspicion of professionals.

See page 175

## UNRECOGNISED BLOCKED SHUNTS ARE DANGEROUS

A 6 year old is admitted to your ward at the start of a holiday weekend with mild headache and vomits once. You know he has a ventriculoperitoneal shunt in place and has been admitted several times with similar symptoms; on each occasion cerebral imaging excluded acute hydrocephalus. After a few hours his symptoms seem to settle. Do you need to trouble the overworked on-call radiographer?

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A group from Great Ormond Street Hospital offers its answer to this common clinical dilemma with a prospective analysis of 53 such children seen during an 8 month period. As expected, drowsiness was the best clinical predictor of shunt malfunction, while headache and vomiting were less so. But no single symptom or was pathognomonic and 4 children are described, not drowsy on presentation, who had been incorrectly diagnosed at first as having normal shunt function.

The authors conclude that in a child who has a shunt in place, clinicians should be suspicious of malfunction if there is no other convincing explanation for their symptoms. When interpreting these, defer to the family's view and always discuss the problem with a tertiary centre. So, no rest for the radiographer.

See page 198

## LUMBAR PUNCTURE—SAFE OR SORRY?

Some years ago there was a spirited correspondence in the *BMJ* on when to perform a lumbar puncture in a febrile child and when to desist.<sup>1</sup> It is likely, in the UK at least, that this investigation is done less than it used to be—perhaps because the common causative organisms are all likely to be sensitive to a third generation cephalosporin. This may have led some clinicians to believe that an aetiological diagnosis was unnecessary when balanced with the risk of coning.

We revisit the question this month, looking at febrile convulsions as well as suspected bacterial meningitis. Riordan and Cant point out that as antibiotic resistance increases, we will have to choose whether to rely on empirical broad-spectrum antibiotic or early lumbar puncture and more selective treatment.

The issue has been complicated by the American Academy of Pediatrics' advice to use vancomycin, as well as a cephalosporin.<sup>2</sup> A retrospective review of all cases of pneumococcal meningitis in Sydney, Australia from 1994–99 sought to determine when empirical use of vancomycin is justifiable and provides useful information on what happens when LP is delayed.

See pages 181, 235, and 238

## A SIDEWAYS LOOK AT BEDWETTING

We are always keen to publish papers proposing and investigating a novel hypothesis. It never occurred to us that asking a child to copy a drawing might elucidate the mechanism of enuresis. Not any old drawing, of course, but the sort of modern art favoured by neuropsychologists—in this case entitled The Rey-Osterrieth figure.

A chance finding was that children with low nocturnal secretion of growth hormone but a normal response to stimulation tests made a pretty poor job of copying the figure with numerous “boundary errors”. A group in Leeds, England asked 34 enuretic children to copy the figure and found that these errors were more likely in children who did not respond to treatment with the vasopressin analogue DDAVP than in those who did.

The authors postulate that errors in performing the test reflect an abnormality of the retinal-hypothalamic-cortical pathways, compatible both with some forms of enuresis as well as growth failure.

See page 188

## REFERENCES

- 1 Harper JR, Lorber J, Hillas Smith G, *et al*. Timing of lumbar puncture in severe childhood meningitis. *BMJ* 1985;291:651–2.
- 2 Anonymous. Therapy for children with invasive pneumococcal infections. American Academy of Pediatrics Committee on Infectious Diseases. *Pediatrics* 1997;99:289–99.