



Human herpesvirus 8 (HHV-8) is known to be the cause of Kaposi sarcoma and primary effusion B-cell lymphoma in adults with HIV infection or immunosuppression from other causes. Serological studies have shown that HHV-8 infection in children is uncommon in the USA but common in some African countries. Now a study in Egypt (*Journal of the American Medical Association* 2002;**287**:1295–1300) has demonstrated the features of primary HHV-8 infection in immunocompetent young children. At a hospital emergency department in Alexandria over a 5 month period (December 1999–April 2000) 36 of 86 (42%) 1–4 year old children with acute fever of unknown cause were HHV-8 seropositive. HHV-8 DNA sequences were detected in the saliva of 11 children and in the plasma of two of these 11 and three others. Six children were thought to have primary HHV-8 infection (PCR-positive, seronegative, repeat serology positive, in all three children tested). Five of these six presented with fever and a craniocaudal maculopapular rash.

Paediatric gastroenterologists in Australia (*Journal of Pediatrics* 2002;**140**:14–9) reviewed the records of 125 infants investigated with upper gastrointestinal biopsies and 24-hour oesophageal pH monitoring because of persistent crying and symptoms suggestive of gastro-oesophageal reflux and oesophagitis. Only 32 (26%) had histological evidence of oesophagitis and only nine of these 32 had abnormal results on pH monitoring. The other 23 were said to have nonreflux oesophagitis. Eleven of the infants with oesophagitis also had inflammatory changes in the stomach or duodenum. The distinction between reflux oesophagitis and cows' milk allergy may be difficult to make.

Lucina is suspicious of studies that purport to show that large numbers of normal children are unhealthy. In Michigan (*Journal of Pediatrics* 2002;**140**:97–102) a Pediatric Sleep Questionnaire was filled in by parents of 1038 children aged 2–14 years waiting to see a doctor for a general paediatric problem. Difficulty sleeping was reported for 41% and sleep terrors, sleep walking, or nocturnal bruxism for 38%; sleep disordered breathing was diagnosed in 11%. Eighteen per cent had more than one symptom.

After disasters, children often suffer long term psychological ill effects and may benefit from treatment. On the Hawaiian island of Kauai schoolchildren were

screened 2 years after a major hurricane (*Archives of Pediatrics and Adolescent Medicine* 2002;**156**:211–6). Of 4258 children screened 248 with high levels of psychological trauma symptoms were randomly assigned to one of three consecutively treated cohorts, children in the second and third cohort acting as controls while waiting for treatment. Psychosocial treatment was associated with significant reductions in symptoms and the benefit persisted 1 year after treatment. Group and individual treatments were equally effective but fewer children dropped out of group treatment.

A study in Aberdeen (*Journal of Medical Genetics* 2002;**39**:251–9) has confirmed the high morbidity rate in children exposed to antiepileptic drugs in utero. Rates of neonatal withdrawal symptoms ranged from 13% (phenobarbitone) to 24% (valproate) and 30% (polytherapy). Other morbidity rates and ranges were: major malformations 9.8% (phenobarbitone) to 16% (phenytoin) and 25.5% (polytherapy); abnormal facies 21% (phenobarbitone) to 70% (valproate), (polytherapy 63%); developmental delay 10% (phenobarbitone) to 33% (phenytoin) and 38% (polytherapy); and behaviour disorder without developmental delay 4.2% (phenytoin) to 14.5% (carbamazepine) and 20% (polytherapy). Joint laxity was more common in children exposed in utero to carbamazepine, valproate, or polytherapy. The rates of morbidity in siblings not exposed in utero to antiepileptic drugs were considerably lower.

A near infrared spectroscopy study of healthy term infants in Italy (*British Journal of Obstetrics and Gynaecology* 2002;**109**:202–6) has shown that cerebral blood volume falls between 2 and 3 hours after birth but the changes were the same whether delivery was vaginal or by caesarean section.

It is often assumed that chronic pain of uncertain origin (chronic benign pain) is due to somatisation and children with these complaints are disproportionate users of healthcare services. Now a general practice study of children in Rotterdam (*British Journal of General Practice* 2002;**52**:211–3) has cast doubt on both of these assumptions. A quarter of respondents reported recent pain lasting for more than 3 months. The annual general practice consultation rate was the same (2.6 consultations) for children with or without such pain. The site of the pain (limbs, abdomen, head, or back) did not influence consultation rates. These authors conclude that

somatisation may not play a major role in children with chronic benign pain. (Lucina is uneasy about the inclusion of back pain as a form of chronic benign pain since she has always looked upon back pain in children as a ringer of alarm bells. Only 3% of this chronic benign pain group, however, complained of back pain.)

How do the press and people in industrialised countries cope with information about serious diseases such as Ebola virus infection in far off countries? A study in Britain (*Social Science and Medicine* 2002;**54**:955–69) has shown that the information provided by broadsheets tends to be more detailed than that in tabloids. Broadsheets refer to specific countries or towns whereas tabloids refer to Africa; broadsheets implicate several factors such as poor medical facilities, eating monkey flesh, poverty, forest environment, and tribal rituals whereas tabloids tend to pick up first on the possible link with monkey flesh. Whatever they read in the newspapers people tend not to relate such illnesses to themselves but to regard them almost as science fiction.

Plastic bottles are often used as homemade spacer devices by children with asthma in developing countries. Three bottles commonly used in this way in Trinidad and Tobago (*West Indian Medical Journal* 2002;**50**:189–93) were compared with a commercially supplied spacer. An analysis of particle sizes showed that the homemade devices were more likely to give an aerosol with a high probability of reaching the lower airway.

There is still controversy about bow legs in young children. True tibia vara is difficult to define and to distinguish from physiological bowing and most bowed legs will straighten with time but in some children the condition may persist or get worse and treatment may need to be considered. In Japan (*Journal of Bone and Joint Surgery* 2002;**84B**:263–8) a diagnosis of infantile tibia vara (metaphyseal-diaphyseal angle > 11°) was made in 46 limbs of 29 infants. Forty of the limbs straightened spontaneously by the age of 6 years (usually but the age of 4 years) without treatment. The six that did not resolve spontaneously were all in a group of 24 limbs which showed more severe radiological changes initially (step-like deformities and irregularities of the medial metaphysis of the proximal tibia). These Japanese clinicians advise no treatment before the age of 4 years but after that age they perform corrective osteotomy for persistent or progressive deformity.