



BOOKS AND BACKS

This middle aged editor had the advantage, in childhood, of a small school, a fixed classroom and his own desk. His—and I assume some of your—offspring are more likely to trudge around a megasite with a heavy sports bag and perhaps the option of an easily invaded locker.

Two studies published this month concentrate on a potentially neglected health problem. A group from Texas found 188 primary (elementary) school children whose backpacks exceeded 10% of their body weight (with one masochist or future special forces recruit carting around 37.4%). Most parents had no idea what their child was carrying around and only seven had ever troubled to weigh the backpack. The authors recommend a targeted prevention programme on backpack safety and quote a mnemonic for parents wishing to carry it out.

However, could they be barking up the wrong cactus? In north west England, researchers identified children aged 11–14 with low back pain (LBP). Prevalence was 23.9%, highest in older girls. Most children carried bags just as heavy as those in Texas, with the majority totting between 2 and 6 kg. The authors found no association between LBP and bag weight, nor how it was carried. Modest associations were found with playing a lot of sport or having a part-time job. What really seemed to matter were psychosocial factors—on multivariate analysis as emotional problems, conduct disorder, and other symptoms proved significant. The authors conclude that LBP may be a manifestation of somatisation.

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THE BEST LAID PLANS . . .

Children may have a lot to carry once they get there but, in the West, they are increasingly likely to travel there by car. The UK government wants to encourage children to walk, thereby increasing physical fitness and reducing pollution.

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Parents are concerned about safety. A suggested intervention is for schools to have travel plans, whereby safety is assured and walking or cycling is encouraged.

Rowland and colleagues conducted a cluster RCT at schools with and without such plans, the test schools receiving 16 hours of expert guidance and being encouraged to set up focus groups, working groups etc while developing a travel plan.

One year on, 9 of the 11 intervention schools (and none of the others) had plans in operation. Disappointingly there was no change in the numbers walking or cycling. Possibly there might have been a small decrease in parental anxiety over traffic danger.

We welcome this paper's negative finding. A lot of time, effort, and money can be spent on well-intentioned interventions which are politically welcome and seem commonsensical, but which are untested. The authors recommend carrying out such interventions initially only within the confines of a properly conducted and sufficiently large RCT.

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MORE FOOD FOR THOUGHT

In April 2002 we published a survey of severe and fatal food allergic reactions in the UK and Ireland.¹ The authors found 8 deaths in 10 years in children under 15 years—a rate of 1 in 800 000 per year. They suggested we should be reassured by this low figure, noted a particular risk to children with asthma and urged caution about the prescription of epinephrine autoinjectors.

The paper provoked lively correspondence through rapid responses to *e-ADC*. Now, two of the paper's critics explore its methodology. They are concerned that some food anaphylaxis deaths may have been certified as asthma, thereby underestimating the risk while—in others—the relationship with food may not have been recognised or reported.

Additionally, they believe the original survey was too exclusive in focussing on hypotensive shock rather than respiratory symptoms as a marker for a severe non-fatal reaction. They cite other surveys to support their contention of underdiagnosis. Finally they suggest criteria for the use of epinephrine. We hope readers will contribute to this important debate by submitting their views to www.archdischild.com.

ATOMS has previously drawn attention to the unreliability of that simplest of asthma outcome measures—wheeze.² Now it's time to turn our attention to coughing children, many of whom we know are difficult to diagnose or treat. For several years I have hoped their problems would be solved by Professor Chang, from the University of Queensland, whose studies on cough we have been delighted to publish in the past.^{3,4} This month she and her colleagues address the precision with which one might use measurements of cough receptor sensitivity (CRS), for example when assessing the effectiveness of an antitussive. They have measured CRS and compared it with results obtained from the same children with a cough meter and diarised cough scores. It transpires that these different variables seem to be measuring different events, with CRS measures and diary scores correlating poorly and the former having only a modest relation with objectively recorded coughing. We have a long way still to go.

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References

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- 3 Chang AB, Phelan PD, Sawyer SM, et al. Cough sensitivity in children with asthma, recurrent cough and cystic fibrosis. *Arch Dis Child* 1997;**77**:331–4.
- 4 Chang AB, Phelan PD, Carlin J, et al. Randomised controlled trial of inhaled salbutamol and beclomethasone for recurrent cough. *Arch Dis Child* 1998;**79**:6–11.