BREAST FEEDING: DOES IT “PROTECT” AGAINST OBESITY?

One of the great strengths of the child health research community in the UK has been the various long term birth cohort studies. Few have been conducted in the US, although the NIH is currently considering and planning the “National Children’s Study” which will enroll 100 000 children around the U.S. and follow them from shortly after birth into adulthood. In a brief report from the Institute of Child Health in London, Parsons and colleagues suggest that the impact of breast feeding on increased body mass index diminishes at 33 years of age. Now that’s long term follow up. See page 793

MEASURING THE HEALTH OF BONES

Many adult diseases have their origins during childhood. The widespread use of inhaled corticosteroids has led to concerns about their long term impact on bone growth and mineralisation. In addition, other drugs and diseases may impact on the health of bones. Fevire, on behalf of the British Paediatric and Adolescent Bone Group, reviews bone densitometry in children as assessed by dual x ray absorptiometry. This is an important review of a complicated test which is likely to become more popular. See page 795

THE MANY CONSEQUENCES OF OBESITY

Most of us are aware of the detrimental impact that obesity has on children and teenagers. Our colleagues from Glasgow, in a systematic review of the literature, have summarised the broad health consequences of obesity. They have organised the information into both short term and long term consequences. Short term issues include: psychological consequences, risk and severity of asthma, and cardiovascular risk factors in childhood. Long term problems include: social and economic effects, persistence of obesity into adulthood, and the impact of childhood obesity on later morbidity and mortality. As you may recall, ADC previously published an evidence-based review on the diagnosis, prevention, and treatment of obesity. Sadly, I doubt that any approach short of a massive, comprehensive public health campaign is likely to be successful in the fight against this epidemic. More modest portions of food at meal times, in restaurants, and from fast food outlets, less TV time, and more exercise, would be a reasonable way to start. One of the few redeeming characteristics of electronic games that many children like to play is that they take two hands to master and it is not possible to play and eat simultaneously. See page 748

SCREENING FOR DEVELOPMENTAL DYSPLASIA OF THE HIP

In twin articles from Bristol, Brown, Dezateux, and colleagues explore various options for screening for developmental dysplasia of the hip, focusing on both health outcomes and cost. The term DDH was adopted about a decade ago following the recognition that about 25% of infants with hip dysplasia develop it after the first month of life. These articles are a result of an arduous process initiated by the Department of Health under the guidance of a Medical Research Council Working Party to reassess the current programme of screening for DDH and the potential role of ultrasound. The authors explore the consequences of three potential strategies: clinical screening alone (Ortolani and Barlow tests); universal static ultrasound along with clinical screening; and selective ultrasound (clinical screening and ultrasound if the infant is breech presentation or there is a first degree family history of DDH). Each strategy comes with trade-offs. Although both universal and selective screening will increase the detection of DDH (and probably improve health outcome) they are the most expensive strategies and also are likely to lead to an increase in the incidence of abduction splinting. It is quite difficult to mandate a single national approach to a complicated medical problem since resources (both human and other) can vary so dramatically from place to place. As we have learned from other “guidelines” or “national recommendations” they need to be adapted “locally” in order to be effective. These articles are an important read for clinicians who care for newborns. See pages 793 and 760

PERTUSSIS—BEWARE

The clinical presentation of pertussis is varied, ranging from apnea in young infants to persistent cough in teenagers and young adults. Although traditionally the diagnosis has been made by culture, more recently polymerase chain reaction methods have become available. Crowcroft and colleagues detail the occurrence of pertussis among young infants admitted to selected UK PICUs between 1998 and 2003 who presented with respiratory failure, apnoea and/or bradycardia, or an acute life threatening episode. Information about the admission of older children is also presented. One in every five infants (25 of 126) had pertussis! Only four were culture positive and only seven were clinically suspected. Increasing both our clinical suspicion and improving our diagnostic testing methods for pertussis is necessary if we are to detect and treat infants and their contacts appropriately. See page 802

ILLUSTRATIONS—IN ERRATUM

The cartoon by Terry McElroy can be found on page 658 of last month’s issue and not page 686 and relates to the article by ML Everard. (Ethical aspects of using radiolabelling in aerosol research. Arch Dis Child 2003;88:659–61). The journal apologises for the error. This month’s cartoons by Jack Maypole can be found on pages 771, 828, and 835.

REFERENCE