Gastroenterology

# Colonic transit times and behaviour profiles in children with defecation disorders

**H Marcovitch**

## Commentary on the paper by Benninga *et al*

When the editorial committee discussed whether to accept the paper by Benninga *et al* for publication,[1] some members raised concerns over the propriety of undertaking rectal manometry on children with abdominal pain. In response, the authors promptly provided their correspondence with the appropriate ethical committee (institutional review board). These revealed that the authors had properly obtained approval for the investigation in constipated children, their siblings (following fully informed consent), and those undergoing endoscopy for other conditions.

We accepted the authors' explanation that the children with a prime complaint of abdominal pain had been referred to their specialised dysmotility clinic. The inference is that those referring the patients considered their pain might be due to constipation.

They wrote: ''… in our outpatient clinic, the standard work-up for all children with functional defecation disorders or functional abdominal pain (irritable bowel syndrome or recurrent abdominal pain) includes a thorough medical history and complete physical examination, colonic transit studies, and rectal barostat studies.''

A related issue was raised recently in the correspondence columns of *Thorax*[2] concerning a paper detailing bronchial biopsies performed, as a research procedure, on children with asthma whose prophylactic medication had been discontinued for the preceding month.[3]

Bush and colleagues[2] pointed out that bronchial biopsy would be included among those high risk procedures which the Royal College of Paediatrics & Child Health considers unjustified for research purposes alone.[4] The investigators, who practice far from the guiding light of the RCPCH, responded that informed consent was received from parents (they did not state whether children consented) and that, in any case, they watched the children closely with a view to exclude any disadvantaged by cessation of prophylaxis.

So here is the dilemma: research projects require ethical committee approval while standard clinical practice may require only informed consent. In the case of the paper published in this issue, it seems that at some point research had elided seamlessly into routine practice. Once a procedure becomes part of a routine clinic work-up then it is presumably no longer a research project. In the case of the *Thorax* paper it appears that research regarded in one country as requiring ethical committee approval demands only parental consent in another.

We decided to publish the paper by Benninga *et al* because it contains valuable information for our readers and we accept there are grey areas, especially in tertiary care, as between research and standard clinical practice. I doubt that we would have published the *Thorax* paper.

I no longer write as editor, but I know that *ADC* does not intend to soften its line, but rather strengthen it, when it comes to ethical standards. During 2002, five papers submitted to *ADC* ended up being reported (after rejection) to the Committee on Publication Ethics (www.publicationethics.org.uk). We have passed on our concerns about four of them to the appropriate head of department or chief executive, asking him or her to mount an enquiry. We are likely to do the same about an alleged attempt at duplicate publication which we are still investigating.

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2 **Bush A**, de Jongste JC, Carlsen K-H. Ultrastructural examination of bronchial specimens from children with moderate asthma (and author's reply). *Thorax* 2003;**58**:187.
3 **Cokugras H**, Akcakaya N, Seckin I, *et al*. Ultrastructural examination of bronchial biopsy specimens from children with moderate asthma. *Thorax* 2001;**56**:25–9.
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Health economics

# Health economics in paediatrics

**P West**

## The literature is smaller in children than for adults

Health economics has developed on a truly massive scale in the past 20 years. As the pressure on health budgets has grown, so too has the ''priesthood'' seen by politicians and funding agencies as well equipped to answer key questions about what health care should and should not be provided. In practice, the tools and answers of health economists are severely limited, by methodology, politics, and ethics. But while not answering key questions, economic analysis can shed light on the questions and give those making the decisions a much clearer idea of the choices they face.

Analysis to help choice of treatment, for governments and insurers, usually falls into one of three categories: cost minimisation; cost effectiveness; and cost utility. However, definitions vary in practical use and many authors have now merged some of these categories into cost effectiveness or cost benefit studies.

A cost minimisation study is the simplest, focusing on comparing treatments with an (assumed or demonstrated) identical outcome. For example, an early UK study compared bottled