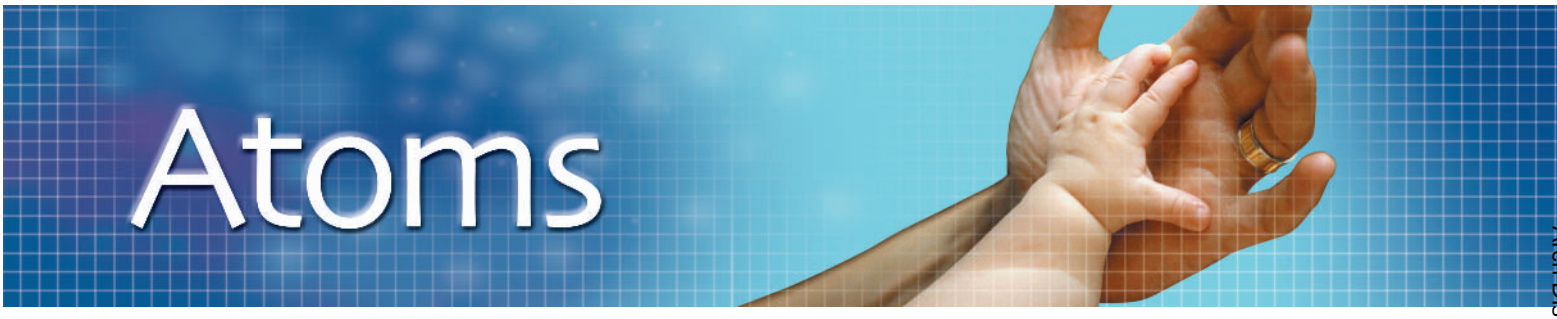

Howard Bauchner, *Editor in Chief*

SSRIS IN THE US – STRUGGLING WITH UNCERTAINTY

Following the lead of the British Government, the FDA in the US has announced a review of the relationship between suicide risk and SSRI drugs.[1] A spokesman for the FDA reported that 109 of 4000 young people who had participated in 25 studies of these medications experienced suicide related behaviours. None had actually committed suicide. In a recent hearing in Washington, protagonists and antagonists battled it out about the value of the medications. Some parents suggested that their use had caused suicidal and aggressive behaviour in their children. Others suggested that the drugs dramatically improved the lives of their children. Is their scientific truth to be had in this debate, or because of the complexity of human behaviour coupled with drug therapy, will we never be certain about the risk of suicide associated with SSRIs? Truth is likely to be elusive, and with an increasingly informed and vociferous public, debates like this one will become far more common. A long, tedious, and complicated campaign to educate the public about risks and benefits of medical tests and interventions is necessary.

INTRAVENOUS IMMUNOGLOBULIN IN CHILDREN WITH CYSTIC FIBROSIS

In this issue, Balfour-Lynn and colleagues, in a retrospective case series, extend their initial report of the success of intravenous immunoglobulin (IVIG) for lung disease associated with cystic fibrosis (CF). Although the gains in FEV_1 and FVC are modest, equally as important is the steroid sparing effect of the treatment – both oral steroid and inhaled steroid use declined significantly following treatment with IVIG. Should all children with CF and lung disease receive IVIG in attempt to reduce steroid effect and improve lung function? The authors suggest that since a large randomised clinical trial is unlikely to be conducted, treatment with IVIG should be considered in all children with CF who have severe obstructive lung disease. We must be aware of the ''slippery slope'' of therapeutic and technological advances—that is, indications for a new or aggressive treatment often become less rigorous with time. Rather than deciding on an individual basis, I believe that the use of IVIG should be tested experimentally, in a sufficient number of children, to provide an answer to the question.

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HEART DISEASE IN CHILDREN WITH SICKLE CELL DISEASE

The care of children with sickle cell disease (SCD) has improved dramatically over the past two decades. The introduction of penicillin prophylaxis dramatically reduced early mortality from sepsis. Chronic transfusion protocols have reduced recurrent stroke. Aggressive inpatient and outpatient management of pain has improved functional status. Hydroxyurea has been found to have beneficial effects for many of the complications of SCD. A group of French investigators describe yet another area in which medical advances may be possible – cardiac insufficiency. Although rare in childhood, 10–30% of adults with SCD suffer from chronic and acute ischaemic complications. These investigators performed thallium-201 single photon emission computed tomography in 22 children with SCD who also had chest pain or ECG or echocardiographic signs suggesting myocardial ischaemia. Fourteen of the children had abnormal scans, with five having fixed defects. Whether these findings have prognostic significance awaits further study.

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INTRODUCTION OF SOLIDS – STILL A CONFUSING ISSUE

The European Society for Paediatric Allergology and Clinical Immunology and the European Society for Paediatric Gastroenterology, Hepatology and Nutrition concur that solid foods should not be introduced until a child reaches 5 months of age. The American Academy of Pediatrics recommends that solids be delayed to 6 months of age, and further recommends that the introduction of certain foods (egg, nuts, etc) be delayed until after a child reaches their first birthday. This issue is revisited in a commentary by Drs Khakoo and Lack, and two original research reports by Zutavern and colleagues and Morgan *et al*. Two recent reports that examined the relationship between the development of type 1 diabetes mellitus and the introduction of foods containing gluten further complicates the discussion. In one study, an increased risk of islet autoimmunity was associated with the introduction of gluten or rice-base cereals before age 3 months or after 7 months. I am mystified by much of the data that examines the relationship between introduction of certain types of food and the development of allergic disease. Many factors influence the development of allergy in infants, including the primary source of early nutrition (breast versus formula), the timing and type of food introduced, and an individual child's susceptibility to allergy—that is, their genetic profile. How we interpret the data for parents is complicated. Although withholding solid foods to the age of 5 or 6 months seems to make sense, most of the parents I know (including my friends and colleagues who are paediatricians) introduce solids by 3–4 months.

See pages 295, 303, and 309

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