Acknowledging contribution to surveillance studies

The Vancouver Protocol (www.icmje.org) provides clear criteria for authorship and the acknowledgment of contributions to scientific publications. However, contributors to health surveillance research, who make such research possible by the identification of cases and the provision of clinical data, have questioned the applicability of these criteria. The International Network of Paediatric Surveillance Units (INoPSU) (www.inopsu.com) is an international association now including 14 national paediatric surveillance units (PSUs) that conduct active surveillance of a range of uncommon conditions of childhood, including infectious and vaccine preventable diseases, childhood injury, and genetic and mental health conditions. Over 7000 child health specialists, many of whom contribute cases to the PSUs on a monthly basis. The population covered is approximately 54 million children under 15 years of age.

Clinicians who report a case to a PSU are asked to provide additional clinical and demographic details to study investigators. Some surveillance studies have significant workload implications for individual clinicians. Although most clinicians will not see a child in any one month with one of the rare conditions under surveillance, a high return rate of the "nil to report" response underpins the quality of the PSU active surveillance mechanism.

At the 3rd meeting of INoPSU in Lisbon in April 2004, the following guidelines on authorship and acknowledgment were proposed for recommendation to investigators conducting epidemiological research through the PSUs:

- To qualify for authorship on reports, individuals must fulfill the Vancouver criteria. However, in acknowledgment of their essential contribution to the work, the addition of the statement "on behalf of contributors to the (national PSU)" following the final author's name is encouraged.

- Investigating teams are encouraged to consider inviting clinicians who have contributed significant data (through notifying cases) onto the study team. These clinicians may have expertise relevant to the analysis or reporting process. Report authorship may then be assigned if appropriate according to the Vancouver Protocol.

- Report authors should consider naming clinicians who have contributed significant data in the acknowledgments section of the report, according to the Vancouver Protocol. Report authors are reminded that the Vancouver Protocol requires that permission must be sought to acknowledge individual clinicians by name.

INoPSU member units will provide these guidelines and a copy of the current version of the Vancouver Protocol to each investigator conducting research through the PSUs, preferably prior to the commencement of the surveillance study. These recommendations may also be applicable to the reporting of other research requiring the provision of clinical data from multiple contributors apart from the study authors.

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On behalf of members of the INoPSU (Portuguese PSU, German PSU, and INoPSU Convenor, Australian PSU)

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References

1 International Committee of Medical Journal Editors (ICMJE): Uniform requirements for manuscripts submitted to biomedical journals: writing and editing for biomedical publication. Haematologica 2004;89:264.


BOOK REVIEWS

Pediatric endocrinology: the requisites in pediatrics


Studying paediatric endocrinology is like staring into the waters of Loch Ness. In the cold light of a Scottish day it is possible to see a few inches into the murky depths, and while most visitors are comfortable seeing the loch’s surface, to consider plumbing the dark waters gives one an eerie feeling about what could lie beneath (encouraged by the locals). Like the mythical monster, the rarer syndromes are often the subject of fragmentary fables, discussed using apocryphal stories (in darkened rooms using faked slides), yet to catch them in the wild needs both an inquisitive mind, an awareness of what one could be hunting for, and the investigative equivalent of a big submarine with echolocation sonar.

This book aims to support paediatricians, paediatric trainees, and paediatric endocrinologists alike and aims to update the clinician on current management and current research developments in paediatric endocrinology (that is, to act as a lifebelt if you’re adrift on the loch and screaming for help). “Requisites” is defined here as the “basic knowledge that is necessary for practise or board review” and aims to provide knowledge up to the level of a tutorial rather than aspiring to be a reference text or source book.

The authors also designed their chapters to maintain a clinical focus. There are seven sections: Carbohydrate Disorders; Sexual Development; Growth; Thyroid; Adrenal Gland; Calcium, Phosphorus, and Bone; and Vasopressin and Disorders of Electrolytes.

Have the authors succeeded with this lifebelt? I believe they have gone a long way to helping the clinician manage common clinical scenarios (such as the hypoglycaemic neonate and type 1 diabetes). Tables and “major points” boxes highlight the key features to be drawn from each chapter. Colour photographs are also stuck grouped at the front of the book, but could be better placed, either incorporated with the relevant text, or have references in the text linking the pictures appropriately.

There is also a useful integration of current research to refresh oft-said information that is readily available in older texts. This provides clinicians with a gauge of current academic thinking, for example important genes in pubertal delay (e.g. leptin), and there is certainly enough detail for consultants wanting to keep one step ahead of enthusiastic registrars, fresh from their membership exams.

The recent proliferation of cases of type II diabetes is also discussed, drawing on extrapolated experience from current paediatric diabetic practice, and adult type II diabetes, while the evidence base develops for management of paediatric type II diabetes. There is a good explanation of the diagnostic features, and their differences from type I diabetes, and management includes good practical advice to parents regarding weight loss, exercise, and reducing TV watching.

All the chapters brought new depths to my understanding of paediatric endocrinology. However, as with other American textbooks, the glucose is measured in mg/dl not mmol/l, and providing a conversion would have helped those clinicians using mmol/l (N.B. mmol/l×18=Mg/dl). Also there is no mention of aspects of paediatric endocrinology specific to the UK, for example NICE (National Institute of Clinical Excellence) guidelines on the use of growth hormone.

There are some paediatric tomes on paediatric endocrinology that are as likely to help you sink faster, with their weight of information, as they are to bring you distressed, and some that are too light and miss out essential information. This however is an excellent resource to access for the clinician in difficulty, is well worth the money, and would be a good lifebelt to choose.

M P Tighe
In their preface to this roughly 200 page book, which chronicles the Cambridge Prader-Willi syndrome (PWS) study, the authors Tony Holland (Chair in Learning Disabilities) and Joyce Whittington (Senior Research Assistant) describe their study as "a process of discovery that included getting to know many people with Prader-Willi syndrome and their families". Following a thorough and painstaking process of identification and ascertainment, the authors managed to identify 96 patients within the Anglia and Oxford Health regions in whom the diagnosis of PWS was secure: 80 had been born with PWS and 16 had developed it following a deletion on the paternal chromosome 15q11–13 region. The prevalence of PWS in the region was later calculated to be 1 in 20 000, with a birth prevalence of 1 in 50 000 (pp 653).

Although fairly comprehensive in scope, although fairly comprehensive in scope, the nearest book in scope would be the WHO book should be	Inheriting the world: the atlas of children's health and the environment


The combination of rigorous diagnostic ascertainment, detailed first hand information, and thorough analysis make this a landmark study. The book is well written, the authors beginning with a succinct description of various aspects of PWS, including the genetic, neuroendocrine, sleep, temperature, and behavior abnormalities. The genetic and neuropathology sections are particularly commendable for being intelligible to readers with little knowledge in these fields.

Only a brief mention of some of the study findings are given here. Ninety nine per cent of patients with PWS can be diagnosed correctly if all four of the following features are present: floppy at birth; weak cry/inactivity in infancy; poor suck at birth; and cretinism. Psychometric testing confirmed a roughly 40 point downward shift in global IQ. Patients with disomy (inheritance of two maternal chromosomes 15 and hence loss of the paternal contribution in the critical 15q11–13 region) showed higher verbal abilities than patients with PWS caused by a deletion on the paternal chromosome 15. Disappointingly, perhaps, the celebrated ability of PWS individuals to complete complicated jigsaw puzzles did not related to enhanced ability and probably reflects plenty of practice related to the repetitive behaviour patterns of the condition! A striking feature was the prevalence of psychotic illness in older patients. After the age of 28 years, 7 of 15 patients had experienced a major psychotic episode. This included all of the five older patients. After the age of 28 years, 7 of 15 patients had experienced a major psychotic episode. This included all of the five

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