

Welcome President Obama

Regardless of one's politics, 4 November 2008 was an historic night in America—the ascendancy of a black man to the Presidency. I never thought I would see it in my lifetime. His calmness, elegance and intelligence are invigorating. Simon Lenton, Vice President of Health Services for the College, has suggested an open letter to President Obama asking him to focus on the health of children, the economy and national and international inequalities. I suspect that he will not focus on healthcare until late in the second year of his presidency. Virtually every pundit—Democrat, Republican and Independent—has emphasised the importance of improving the US (and world-wide) economy. If and when the economy improves, so too will the health of children. He has said little about justice and human rights—unfortunately the last few months of the presidential campaign were dominated by discussion and debate about the economy. But I am hopeful that rather than leading with the sword, he will make every effort to reduce armed conflict around the world. Nothing threatens child health more than the twin evils of war and poverty!

NICE

Established in 1999, the National Institute for Clinical Excellence (NICE) dominates British healthcare. Given the rapid introduction of newer, and ever more costly treatments, the recommendations of NICE are closely watched by patients, doctors and drug manufacturers. In a wide-ranging and superb review of NICE, Robert Steinbrook, a national policy correspondent for *New England Journal of Medicine (NEJM)*, reviews its origins, successes and challenges.¹ NICE, or a NICE-like federal agency, has been suggested as one way to curb the US appetite to spend more and more dollars on healthcare. Although I think the “evidence-base” for many of the decisions that NICE makes is excellent, whether such an agency would be palatable to the US population is an entirely different issue. Americans do not take kindly to having their options limited, regardless of the evidence or cost.

Drugs for asthma – changes over a decade

Turner and colleagues, using the General Practice Research Database, which covers 484 practices in England, Scotland, Wales and Northern Ireland, describe the use of asthma drugs between 1992 and 2004. Their key findings: use of bronchodilator monotherapy peaked in 1995 at 1.8% and fell to 0.4% in 2004; the percent of children 0–4 years receiving high dose and very high-dose inhaled corticoid steroids (ICS) peaked in the late 1990s but declined to 2.5% and 2.0% respectively by 2004. This is in contrast to children aged 5–11 years in which high dose ICS fell from 10.1% in the late 1990s to 3.6% in 2004, but very high dose ICS increased from 1.1% in 1992 to 4.6% in 2004. These studies likely reflect the influence of national guidelines and other new data. *See page 16*

Preventing the development of atopic disease

Food allergies are on the rise. There has been renewed interest in developing primary prevention strategies. The approach usually involves the manipulation of early infant diet. Some have argued that early exposure to highly allergic foods like eggs stimulates the development of allergy, while others believe that early exposure may in fact prevent the development of allergy. The timing and type of introduction of solid foods is hotly debated. In this issue of *ADC*, Alm and colleagues from Sweden tell us that at least in their country the early introduction of fish into the diet appears to reduce the likelihood of the development of eczema. A recent set of new recommendations from the American Academy of Pediatrics (AAP)² are more consistent with those of the European Society of Paediatric Gastroenterology. The AAP suggests that few data exist that manipulating a pregnant woman's diet impacts on the development of atopy in their offspring, in high risk infants (positive family history of atopy) exclusive breast feeding likely reduces the development of atopic disease and the use of hydrolysed formulas may be helpful. For infants who are not at high risk of developing atopy, data to guide our recommendations are inconsistent. *See page 11*

A matter of placement

I would like to draw your attention to the article by Ramesh and colleagues in the November issue of the *Fetal & Neonatal Edition*.³ The article describes the ventilatory strategy used in the early management of infants with congenital central hypoventilation syndrome. The article was placed in *F&N* although it could have just as easily been in the regular *ADC* edition. In general articles related to care in the neonatal period are placed in *F&N* while follow-up studies of newborn infants may appear in either issue. The lack of consistency reflects uncertainty as to who cares for these infants. If you have a strategy to deal with where these types of articles should go, please feel free to contact me directly (howard.bauchner@bmc.org).

This month in *F&N*

- ▶ The resuscitation and treatment of infants born at less than 26 weeks gestation is highly variable within and between countries. Wilkinson and colleagues presents a framework for the care of these infants at birth. *See page F2*
- ▶ The role of *Ureaplasma* species in diseases associated with prematurity remains under investigation. In a study from Japan, Oue *et al* suggest they may play a role in the development of bronchopulmonary dysplasia. *See page F17*
- ▶ During the past decade we have come to recognise that invasive fungal infection is an important cause of morbidity and mortality in very low birthweight infants. Brecht, Clerihew and McGuire review the epidemiology, diagnosis, prevention and treatment of invasive fungal infection. *See page F65*

References

1. Steinbrook R. Saying no isn't NICE – the travails of Britain's National Institute for Health and Clinical Excellence. *N Eng J Med* 2008;**259**:1977–81.
2. Greer FR, Sicherer SH, Burks AW, and Committee on Nutrition and Section on Allergy and Immunology. Effects of early nutritional interventions on the development of atopic disease in infants and children: the role of maternal dietary restriction, breastfeeding, timing of introduction of complementary foods, and hydrolyzed formulas. *Pediatrics* 2008;**121**:183–91.
3. Ramesh P, Boit P, Samuels M. Mask ventilation in the early management of congenital central hypoventilation syndrome. *Arch Dis Child Fetal Neonatal Ed* 2008;**93**:F400–3.