

Sleep disordered breathing and growth

Sleep-disordered breathing may interfere with growth. Interestingly, it has been associated with both weight-faltering and obesity. Although it is difficult to distinguish SDB from primary snoring on clinical grounds, sleep studies can assure a definitive diagnosis. Bonuck and colleagues conducted a systematic review of 20 studies that reported height, weight, IGF-1 or IGFBP-3 before and after adenotonsillectomy in children with disturbed sleep. They found that all four outcomes improved significantly after adenotonsillectomy. Unfortunately, not all of the studies used polysomnography as the basis for inclusion in the study. There are numerous methodological issues that have become increasingly recognised as threats to the validity and generalisability of meta-analyses. First, sometimes the results from individual studies are so varied, so-called heterogeneous, or the overall summary result is dominated by a few studies, that the results may not be valid. Second, particularly when the analysis involves a drug, in contrast to a radiological or surgical procedure, the dose and length of therapy may vary substantially between studies, so that although the results suggest that a particular drug is superior, it is not possible to know what dose, or length of therapy is best. In my weight-faltering clinic, beginning around age 3, we carefully assess all children for enlarged tonsils and possible obstructive sleep apnoea. Growth improves in only about half the children who undergo surgery for SDB. *See page 83*

Improving outcomes of children with expressive language delay

Expressive language delay (ELD) is among the most prevalent developmental problems in young children. It usually occurs in isolation—the child is otherwise well, with normal receptive language skills. Buschmann and colleagues from Germany conducted a randomised

clinical trial in which 47 children, beginning at age 2, with ELD were assigned to either a mother-focused intervention or a waiting list. In seven 2-hour sessions conducted over three months, followed by one additional 3-hour session six months later, mothers were taught child-oriented, language modelling techniques, such as sharing picture books. At three years of age, 75% of the children in the intervention group showed normal expressive language compared to 44% in the waiting group. Does this problem warrant an intervention? Anne O'Hare, in an accompanying perspective, reviews this paper in light of the 2005 statement from the UK National Screening Committee Child Health subgroup report on speech and language delay that suggested the prognosis of a child with isolated ELD presenting under the age of 3 is generally good, unless parents express concern. She goes on to write that although many worried parents may want therapy for their children, there are likely numerous long-term benefits of a parent-focused intervention.

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Treating constipation

Oftentimes articles produce conflicting results. What a delight when different authors come to the same conclusion. Pijpers and colleagues from The Netherlands, in a systematic review of the literature, found that there was insufficient evidence to support any laxative treatment over placebo for the treatment of functional constipation. However there was a suggestion that polyethylene glycol (PEG) achieved more treatment success than other drugs. This conclusion is consistent with the paper by Candy and Belsey in which they reviewed seven studies involving 594 children with primary constipation who were treated with PEG, lactulose, milk of magnesia, or placebo, and also found PEG to be superior. For functional constipation it appears as though PEG is the treatment of choice.

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Introducing solid foods into the diet of infants

Previously I have written about the complex question—when should solid foods be introduced into the diet of infants? The importance of this question is obvious. Every child is affected by this issue. HIV/AIDS, the increase in allergic disease, and the renewed interest in the Barker hypothesis makes this question even more relevant. In addition, it has become clearer that the answer may be different depending upon where an infant lives and his or her genetic make-up, and that it may not only be the “timing” of the introduction of solids, but what type of food is introduced. Quigley and colleagues provide more data. Using the Millennium Cohort Study, they found no relation between the timing of the introduction of solid foods and the monthly risk of hospitalisation for diarrhoea. Buried in the paper is an interesting observation—the vast majority of these 15 980 infants had solid foods introduced by 4 months of age, despite the WHO recommendation that solids not be introduced before six months of age. This is not the first time that the collective wisdom of parents is different from that of an official governing body. Martin Ward Platt adds an enlightening perspective about this paper and the issue in general. *See page 148*

This month in E&P

We debut another new section, Teaching and Learning in this issue of Education and Practice. In many regards this section represents the philosophical basis of Education and Practice—how do we teach and learn? Under the guidance of Drs. Diwakar and Murdoch-Easton, they have already commissioned 10 pieces that will be published over the next two years. Although the “science” of teaching and learning remains limited, I still believe there is a great deal to learn from experts. In this issue, Tony Waterston shares his thoughts on learning about advocacy, a subject near and dear to his heart, and one in which he possesses a great deal of experience.