The return of rickets
That vitamin D deficiency has re-emerged as a significant clinical and public health problem will come as little surprise to some readers from their own clinical experience. Over the last 10 years or so, Archives has carried a number of papers highlighting the problem in the UK and elsewhere, and Ahmed et al show how rapidly the problem has increased over the last decade in Glasgow. Since for many paediatricians rickets lingers only as a folk memory, it is timely and important that we are reminded of the various manifestations of the condition. Perhaps the most frustrating aspect is that the disease is, in principle, entirely preventable. In the accompanying editorial, Davies and Shaw examine the possibilities for prevention and remind us that vitamin D deficiency is not just about the migration of populations used to high levels of powerful sunlight in their native environments. Over-zealous protection of children from ultraviolet skin damage, combined with indoor sedentary life styles, and obesity itself, are placing many other children at risk of vitamin D deficiency in new ways. Yet in focusing on children we must not forget that one of the most important ways of improving vitamin D status, at least for infants, is to ensure that their mothers are not deficient or borderline deficient during pregnancy. The antenatal period can serve both as an opportunity for ensuring mothers at risk of personal deficiency are appropriately treated, and for sensitising them to the need for ongoing supplementation to prevent deficiency in their children – perhaps throughout childhood, though certainly in the preschool years. Never was the need for some joined-up thinking more acute. See pages 694 and 614.

Sex, seizures and drugs
What is the best drug strategy to use when starting a girl on antiepileptic medication? For many years paediatricians have prescribed sodium valproate with no consideration at all for how long she may need to take it, and what the consequences might be if she remains on this treatment in her reproductive years. There is no longer any excuse for ignoring the consequences: valproate has joined the increasing list of anticonvulsant drugs that affect the fetus less as a teratogen, and more as a drug that interferes with aspects of neurodevelopment that have long-term consequences for the child in the next generation. So which drugs are potentially harmful and which are probably safe? Cummings et al have added an important paper to an increasing literature that suggests that both sodium valproate and carbamazepine are best avoided during pregnancy, and that lamotrigine seems to have little or no adverse effect on the subsequent neurodevelopment of the exposed infant. This information must translate into the way we treat children. We have no idea, at the outset, as to how long anticonvulsant treatment may need to continue in most children with uncomplicated epilepsy. It is time to recognise that this being so, the choices we make in girls may have to exclude sodium valproate and carbamazepine and include other drugs such as lamotrigine. See page 643.

Playing safe or wasting resources?
In no human endeavour can we get things right 100% of the time, and this very much includes the assessment of children presenting with illness. How ill are they? Do they have something serious? Does this child need admission, observation for a period of time, or can they go home? All of these are complex clinical judgements, made against the backdrop of the fact that serious illness remains rare among the rising tide of children brought by worried parents to be assessed for their transient or mild diseases. At the same time, we are looking for alternatives to traditional models of initial first contact: in the UK these include National Health Service direct and triage by trained people such as emergency care practitioners; other models exist around the world. O’Keefe et al show that at the community level in Scotland, emergency care practitioners seemed to err on the side of caution and were less effective at discharging patients, though they also initiated less treatment. This may increase costs – presumably the opposite of the intended outcome. At the other end of the telescope we have the issue of undertriage: Seiger et al in The Netherlands found that 0.9% of children seen in an emergency department setting were undertriaged using the Manchester Triage System, of which half were considered at risk of severe consequences. Interestingly, the proper interpretation of measured vital signs seemed to be the missing ingredient, so there is an important ‘back to basics’ message here. See pages 658 and 653.

Mediation
One of our leading articles, by Meller and Barclay, addresses the use of mediation when intractable differences of opinion emerge between clinical teams and parents, and draws to our attention the existence of a funded pilot of this approach of which we all need to be aware. We editors must take some editorial responsibility for not noticing that we published a similar piece as a Perspective in 2005.1 Historically the resolution of such cases has usually been through a Court judgement; yet we know that this route is unpleasant and potentially damaging to all parties. Independent mediation has potentially a lot to offer as an alternative route in these difficult cases. See page 619.

REFERENCE