Highlights from this issue

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Outcome of cardiac surgery

There have been considerable technological advances in the surgical management, medical and intensive care support for children with congenital heart disease (CHD) over the last 50 years. This has resulted in a significant fall in mortality year on year with increased survival into adult life. In an impressive and important publication Knowles *et al* explore this through period and birth cohort analysis using routinely collected mortality and population data (England and Wales). Absolute numbers of CHD related deaths under age 15 years have fallen from 1460 in 1959 to 154 in 2009 with the greatest improvements being seen in survival in infancy (reducing from 60% to 22% of all deaths) with now 67% (2004–2008) of deaths due to CHD being in adults. The authors predict a continued decline in mortality with further increases in survival into adulthood and relate these changes to the improvements in management through technological advances over the last 50 years. The wider and international relevance is explored in the accompanying editorial. ***See pages 859 and 861***

Enteroviral meningitis without pleocytosis

Non-polio enteroviruses are the most commonly identified cause of aseptic meningitis. Modern techniques suggest the pick up on tested cerebrospinal fluid is high. Yun *et al* review a retrospective dataset of 390 infants and children with enteroviral meningitis diagnosed by reverse transcription PCR. 16% did not have CSF pleocytosis (68% of neonates) according to agreed criteria. Multivariate analysis showed younger age, lower peripheral white blood cell count and shorter duration between symptoms and lumbar puncture were associated with the absence of pleocytosis. The authors rightly suggest in children investigated for suspected meningitis CSF enterovirus PCR testing should be routine, even in the absence of CSF pleocytosis and especially in infancy. ***See page 874***

Complex regional pain syndrome

Complex regional pain syndrome is a clinical syndrome that affects one or more extremities and is characterised by persistent pain disproportionate to any inciting event, and at least one sign of autonomic dysfunction in the affected limb. The aetiology is poorly understood and mulitifactorial with minor trauma often being the precipitating event. Management is multidisciplinary and rehabilitative with a reasonable outcome in most cases. Richards *et al* report a case series of young people who developed complex regional pain syndrome following immunisation raising awareness of this as a potential trigger and highlighting important issues in the assessment, management and prognosis of this often difficult to manage condition. ***See page 913***

Pain and behaviour changes following surgery

Hospitalisation is a stressful event in a child's life and it is well known that some children take some time to settle once home. Power *et al* look at this in a cohort of children admitted for elective surgery monitoring for pain and problem behaviour in the coming weeks. Both were common on day 2 post discharge with pain (25%) and problem behaviour (32%) persisting at 4 weeks. Risk factors included previous painful experiences, parental and child anxiety and parental level of education. The authors rightly highlight these as factors that should be considered when surgery is planned in the hope that interventions can impact. ***See page 879***

Checking pregnancy status in adolescent girls before surgery

Anaesthesia, surgery and ionising radiation should be avoided, if possible, during pregnancy because of the potential risk to the patient and fetus. Both NICE (2003) and NPSA (2010) guidance recommends that pregnancy status should be established before procedures are undertaken in women of child bearing age. This is not always the case. Donaldson *et al* review the implementation of the guidance and demonstrate incomplete and inconsistent application with many young people not being questioned regarding pregnancy, a poor awareness of the risks, lack of awareness of national guidance and an overall failure to address this issue. In the context of high teenage pregnancy rates (UK has the highest teenage pregnancy rate in Europe) this is of relevance to us all as paediatricians. In the accompanying editorial Larcher discusses this sensitive issue reviewing the background and recommending practical ways forward including sensitive questioning and selective testing properly implemented, recorded and audited in order to improve our awareness of pregnancy status before procedures are done and thereby safety of the young person and potentially their fetus. ***See pages 895 and 857***

Opportunistic health screening of adolescents

Wilson *et al* report their experiences of opportunistic screening in 114 adolescents admitted for surgical procedures to an adolescent ward. The formatted list of questions was based on home, education, activities, drugs, sexual health and suchlike. Interestingly 30% highlighted areas of concern requiring an intervention including referrals to the adolescent medicine clinic, school services and psychology. The authors highlight the impact recommending that further research should involve the participation of young people and should focus on the outcomes, feasibility, acceptability and resource implications of such screening. ***See page 919***

In *E&P* this month

Limp is common in paediatric practice and not always benign. In the popular series of Interpretations Eve Smith *et al* discuss the child with a limp; a symptom not a diagnosis giving background information, case examples and practical advice on assessment and management. The authors include guidance on examination, red flag symptoms and a summary of common pitfalls to be avoided. It is a useful article to work through and (hopefully) as a result feel more able to deal effectively with this common clinical problem. It may be one to write a reflective note in your portfolio on.