

# Highlights from this issue

R Mark Beattie, *Editor-in-Chief*

## Ultrasound screening for CDH

Clarke *et al* report their 20 year experience of selective ultrasound screening for congenital dislocation of the hip in this issue. The dataset is of considerable interest. Of 107 440 live births 20 344 (18.9%) were referred for ultrasound assessments based on clinical signs (2 weeks) or risk factors (6 weeks). 774 were diagnosed with dysplasia. There were no false negatives on follow-up, that is, no infants with a normal ultrasound examination re-presented with hip dysplasia. 37 presented late (after 12 weeks), none of whom had had clinical signs or risk factors. Pavlik's harness treatment of dysplasia was successful in 94.6%. The remainder and the late presenters required surgical intervention. The overall surgery rate fell during the study period from 1.2/1000 prescreening to 0.74/1000. The low false negative rate, low rate of late presenters and reduction in surgery rate are impressive. *See page 423*

## Role of cystovaginoscopy in vulvovaginitis

Vulvovaginitis is common in prepubertal girls and can be challenging to manage particularly if recurrent or chronic. Further investigation including cystovaginoscopy can be considered. Ram *et al* report their experience of 48 patients over 10 years who underwent the procedure. This was a refractory group referred with a median duration of symptoms of 12 months (range 8–33). Excluding one child who had a solitary kidney on ultrasound they report that 15 had mild non-specific cystitis, three labial adhesions and the rest were normal. All received strict hygiene advice and 39/44 in whom there was follow-up reported marked improvement or complete cure at 3–6 months. The authors conclude that additional investigation by cystovaginoscopy does not impact on management of recurrent or chronic vulvovaginitis. *See page 477*

## Monitoring obesity: role of BMI charts

Body mass index (BMI) is generally accepted as the best method to assess

and monitor obesity in the clinical setting, although it is less clear what should be viewed as success. Rudolf *et al* have explored clinician interpretation of changes in BMI using the 1995 charts based on 1990 UK Growth data. Four experienced clinicians showed good agreement categorising progress as marked increase in obesity; some increase in obesity; no real change in obesity; some decrease in obesity; marked decrease in obesity, correlating well with change in obesity as measured by change in BMI and fat mass SD scores recorded by DEXA. Specific guidance is given to aid the clinician in the interpretation of BMI measurements over time and thereby better support the management of obesity in the clinical setting. *See page 418*

## Night sweats

Night sweats are commonly reported although there is only sparse data on their significance in childhood (and adults), particularly if they relate to serious underlying disease. Night sweats are defined as sweating that occurs only or mainly at night. In data from more than 6000 primary school children in Hong Kong, So and colleagues report 11.7% have had night sweats more than once a week in the previous 12 months. Significant associations included male gender, atopic and respiratory disease (including insomnia), hyperactivity and anxiety. This would be an interesting area for further study and certainly should prompt us consider these associations when we see children with night sweats but also to ask about night sweats in children presenting with these associated conditions. *See page 470*

## Living on dialysis

Children with end stage renal disease require dialysis or transplant to survive. Dialysis is complex, invasive and restrictive and this has a significant impact on quality of life. Tjaden *et al* in their systematic review explore the evidence and report five themes underlying children's experience of dialysis: loss of control, restrictive lifestyles,

coping strategies, managing treatment and feeling different. These themes are explored in detail. Children's hope for and expectations of transplantation and uncertainties about their long-term future are highlighted. The challenge for the healthcare team is to address and impact on these issues if we want to improved physical, psychosocial and treatment outcomes for children on dialysis. *See page 395*

## Does audit change practice

Gastroenteritis is common in childhood and a common cause of admission to hospital. Rehydration should be enteral (oral or nasogastric) rather than intravenous in the majority of cases. Fox *et al* report repeat audits from South Wales in 1999, 2002, 2004 and 2009 with intravenous hydration rates of 20%, 15%, 4% and 6% respectively. The most significant change occurred after an implementation programme in 2004 and this was maintained. The authors discuss this in terms of audit suggesting a clear multi-faceted, planned implementation program is necessary to successfully change practice. Although this is discussed in the context of the management of gastroenteritis the principle applies to many areas of practice. *See page 415*

## In FNN this month

Tim Cole and colleagues discuss designing the new UK WHO growth charts to enhance assessment of growth around term. This includes separation of the preterm UK birth weight reference from the WHO standard and includes explanation as to why there are no centile lines between 0 and 2 weeks. The article gives useful and practical advice for clinicians using the charts. Quigley *et al* report school performance at age 5 in children born preterm, late preterm, early term and full term with a less good outcome of infants born at 37–38 weeks (early term) than 39–41 weeks (full term). Neil Marlow discusses this and the concept of full term in an accompanying editorial.