

Highlights from this issue

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more common than it was in the 1970s. *See page 269.*

COMPLICATIONS OF BEING UNDERWEIGHT

Children with potentially life-threatening levels of being underweight present to paediatricians. This includes children and young people with eating disorders and many other potential acute/chronic conditions. Recognition of at risk individuals, the potential complications and the potential complications of treatment are crucial. Hudson and colleagues report the level of knowledge on the assessment and management of underweight in children and young people amongst middle grade, who may see the children first, in England and Wales. The authors highlight significant knowledge gaps including the most appropriate measure of underweight, cardiovascular complications and knowledge of the re-feeding syndrome. The authors discuss and reference these specific issues. The knowledge gap does however need to be addressed and the authors advocate enhanced training packages including the inclusion of severe underweight in the curricula for acute resuscitation courses which we should all support. *See page 309.*

IN E&P THIS MONTH

There is an excellent collection of articles in the 'How to use....' series covering a wide range of topics including autism assessment, lupus anticoagulant and auto-antibody screening. All are carefully put together, focused and informative. I would like to commend Sam Behjati who edits this popular series and in particular his excellent paper on how to write an interpretations paper. Please contact him if you are interested in writing for this section. This month also sees the relaunch of the guideline reviews with an excellent summary then commentary of the new NICE guidance on the management of neutropenic sepsis in cancer patients. Many of the papers in *Education and Practice* now contain questions to help with continuing professional development which we hope is helpful. We are also looking for self assessment questions to be submitted for a new section 'Epilogue'—so please refer to the instructions for authors and send in.

HYPNOTHERAPY AND IRRITABLE BOWEL SYNDROME

Functional abdominal pain and irritable bowel syndrome are common in children, frequently seen by paediatricians and often difficult to manage. The underlying pathophysiological mechanisms are complex with many potential contributing factors, the impact on patients and their families can be considerable and treatment can be very difficult particularly in the most symptomatic cases. Rutten and colleagues report a systematic review of the evidence base for gut directed hypnotherapy in such children looking at impact on pain, quality of life and school attendance. The studies (limited) are generally positive and suggest significant benefit. Peter Whorwell in an accompanying editorial (and the authors of the review) suggest that we should consider hypnotherapy as a first line treatment option in children with functional abdominal pain and irritable bowel syndrome, and, certainly for a group of children we don't manage particularly well, this should be considered as a potentially cost effective strategy that may have a positive long term impact for children and their families. *See pages 252 and 243.*

CAPILLARY REFILL TIME

The capillary refill time is an assessment tool well known to us all and routinely used to evaluate circulatory status. Prolonged refill time is suggestive of poor peripheral perfusion but can be affected by many other factors including environment, lighting, temperature and technique. Recommended sites include the fingertip and sternum (Advanced life support group, the resuscitation council, NICE) with the standard technique being to press firmly 5 s and then measure the time taken for the skin to return to a normal colour with 'normal' being less than 2 s. Crook and Taylor investigate the agreement between fingertip and sternum in 92 children who are well, controlling for other variable as listed above. The results are of interest: finger tip refill time (mean 1.08, range 0.05–2.78) is faster than sternum refill time (mean 1.5, range 0.85–2.38). Interestingly there was no relationship (in individuals) between sternum and finger tip capillary refill time—the detailed statistics are in the paper. The important practical implication highlighted by the authors is that the two

measurements can't therefore be used interchangeably in the same patient. The authors give a useful five point recommendation for carrying out the capillary refill test and suggest further evaluation and assessment of the practicalities and reliability of this commonly used test. *See page 265.*

RESTING HEART RATE

Resting heart rate is increasingly recognised as a prognostic marker for long term cardiovascular disease, with elevated heart rate predictive of elevated blood pressure. There is less data in children. Kwok and colleagues assess this by assessment of resting heart rate, blood pressure, anthropometric data and exercise frequency in 14, 842 children across 18 districts in Hong Kong (age range 6–18). In some respects unsurprisingly, high resting heart rate was associated with elevated blood pressure and inactivity (controlled for age and sex) with resting heart rate more closely linked with fatness than body size, with a positive independent association with weight circumference in boys ($p < 0.001$). The interesting presumption from the dataset is that exercise associated with a lower resting heart rate and lower blood pressure is likely to improve long term health outcomes, although longitudinal data will be needed to answer the question as to whether lifestyle changes that reduce resting heart rate will impact on health outcomes long term. *See page 287.*

GROWING UP BEFORE GROWING OUT

In a whole population study of height, weight and obesity prevalence Smith and colleagues make some interesting observations. Their data set includes heights and weights collected at school entry (North East Scotland 194 391 children born between 1970–2006). Height SDS rose for those born between 1970 and 2000 but has been static since; 0.8 mm/year for those born between 1970 and 1992. Obesity fell initially (during the initial phase of height increase), rising between 1976 (1.3%) and 1998 (6.9%) but falling subsequently (5.7%, 2006). In summary therefore, looking at trends, the increase in height preceded the increase in weight and obesity levels have now stabilised. However, although 5–6-year olds are 2–3 cm taller obesity is still significantly