Highlights from this issue

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HOW COMMON IS CHRONIC FATIGUE SYNDROME

Most paediatricians regularly see children with chronic fatigue syndrome although the epidemiology has not been well studied. In this issue Esther Crawley reviews what is currently known. There are various definitions—fatigue has to be chronic and disabling, last at least 3 months and be accompanied by 1–4 additional symptoms. Data from the Avon Longitudinal Study of Parents and Children at age 13 showed a prevalence of 2.4% (3 months) and 0.9% (6 months). Many sufferers never consult a doctor. Female gender, genetics and viruses are all risk factors. The role of exercise versus sedentary behaviour is poorly understood. Anxiety and depression are both risk factors and complications. Contrary to widely held assumptions there is no particular social class predominance although socio-economic and family factors are clearly relevant. In general the outcome in childhood is good with recognition of the condition, child and family engagement and appropriate multidisciplinary input. *See page 171*.

BRUISING IN CHILDREN ASSESSED FOR SUSPECTED PHYSICAL ABUSE

Bruising is common in children and is the most common injury sustained by children who have been physically abused. Kemp and colleagues report the characteristics of bruising and mode of presentation of 519 children (age less than 6 years) referred for assessment of suspected physical abuse. Bruising was more common in children in whom physical abuse was confirmed (89%) than in children in whom physical abuse was excluded (69.9%). The odds of a bruise on the buttock or genitalia, ear, cheek, neck, trunk, head, front of thighs, upper arm were significantly greater in children in whom physical abuse was confirmed. Petechiae, linear bruising, bruising with a distinct pattern bruising, bruising in clusters, additional injuries or child known to social services were also significantly more likely in children in whom physical abuse was confirmed. All individuals referred with suspected physical abuse require a careful clinical assessment, multidisciplinary assessment and discussion. This paper provides (on a population basis) further understanding of the factors that should be considered when a child is referred with bruising and should help improve the quality of the decisions made. In an accompanying editorial Hilary Cass discusses the wider issues of increasing the evidence base, enhancing training and providing mentoring for paediatricians who regularly assess children who may have been abused. *See pages 108 and 101*.

PEER MENTORING

Mentoring is important for the personal and professional development of doctors. It should be considered separately from educational supervision, appraisal and assessment, and can be from peers, seniors and colleagues from different specialities (and professions) and delivered both informally and formally. Many of the junior doctors now work mostly shifts and the traditional 'firm' structure is less evident which can make sustained developmental relationships with colleagues harder to establish. Eisen and colleagues report their experience with a peer mentoring scheme. Mentors (trainees) were selected by competitive interview and trained and then matched to more junior trainees. Peer mentor and mentees reported high satisfaction rates, acquisition of new and transferable skills and changed behaviours. There seems to be a high demand for such schemes and their implementation will be essential if we want to enthuse and nurture the next generation of paediatricians. *See page 142*.

PHYSICAL ILLNESS IN LOOKED-AFTER CHILDREN

Children looked after by local authorities are known to have higher health care needs with a higher prevalence of physical illnesses than those in their own homes. Martin and colleagues compare the reported point prevalence of chronic physical illness in a cross sectional survey, using data from a national survey. Data was collected on 1253 looked after children and compared with 10 438 in their own homes. Epilepsy, cystic fibrosis and cerebral palsy were more commonly reported in looked after children (ORs 4.13, 4.2, 7.26). There was no difference in glue ear, diabetes mellitus, spina bifida or cancer. Somewhat surprisingly asthma, eczema and hay fever were less common (ORs 0.63, 0.61, 0.36). The overall physical illness burden is high. It may be the lower incidence of atopic disease reflects under reporting. The importance of transferring accurate information and engaging health in this vulnerable group is discussed. Looked after children often have frequent changes in caregivers and healthcare providers and looked after status is associated with low socio-economic class which further contributes to physical ill health. Gita Croft in an accompanying editorial discusses the important issue relevant to all paediatricians of meeting the physical health needs of our looked after children. *See pages 103 and 99*.

SLEEP PATTERNS IN CHILDREN WITH AUTISM

Children with autistic spectrum disorders are more likely to have disturbed sleep. Humphreys and colleagues use data from the Avon Longitudinal Study of Parents and Children (cohort 14 062 children born 1991/2) to report sleep patterns. Data is by parent report collected at 8 time points from age 6 months to 11 years in the 73 children with ASD identified from health and education records. From age 30 months children with ASD slept less each day than their peers (17–43 min, peak at 81 months assessment), significant even after adjusting for sex, ethnicity, high parity and epilepsy. Reduction in sleep was due to changes in night rather than day time sleep. Frequent night wakening (3 or more times a night) was also more common (18–42 months). The authors speculate on causation and emphasise the importance of assessing sleep disturbances early in children with ASD and offer support and guidance and at least consider the use of melatonin. *See pages 114 and 119*.

TACKLING THE OBESITY CRISIS

In early 2013, the Academy of Medical Royal Colleges published a report 'Measuring up' with 10 recommendations targeted at the health care professionals, at the obesogenic environment and towards making healthy choices the easy choices. Alan Jackson and colleagues review the recommendations and ask the question—Tackling the Obesity Crisis: How do we measure up—looking at the problem, need to intervene, means and end points of intervention, examples of success and role of doctors in leading the campaign. Essential reading for all paediatricians. *See page 95*.