MANAGING CHRONIC PAIN
Chronic pain is complex and challenging and often poorly recognised, evaluated and managed leading to unnecessary distress for children and families and poor health outcomes. In a comprehensive review Rajapakse and colleagues discuss the presentation and management. The review emphasises the complex pathophysiology whereby the severity and impact of chronic pain on everyday function is shaped by the complex interaction of biological, psychological and social factors that determine the experience of pain for each individual, rather than a straightforward reflection of the severity of disease or extent of tissue damage. The authors discuss this biopsychosocial concept of chronic pain, the evidence base for management strategies and a ‘best’ approach to overall care. Specific conditions including neuropathic pain, complex regional pain syndrome, musculoskeletal pain, abdominal pain and headache are also discussed. It is a helpful, up to date and relevant review and relevant to everyday clinical practice. See page 474.

PREVENTION OF RESPIRATORY SYNCYTIAL VIRUS INFECTION
Most babies will acquire RSV during infancy which globally is estimated to be responsible for 33.8 million new lower respiratory infections per year in the under 5’s, with a significant mortality mostly in resource poor settings. Murray and colleagues review recent developments including the safety, efficacy and cost effectiveness of Palivizumab prophylaxis which is used in high risk groups including prematurity, low birth weight and congenital heart disease although not universally available or affordable. There are potential candidate vaccines for active immunisation and new antiviral drugs being studied which are also discussed. The potential to impact on this common infection is exciting although based on current knowledge and until a safe and effective vaccine is available population level approaches to prevent severe RSV LRTI should continue to focus on reducing prenatal and environmental risk factors including prematurity, smoking and improving hygiene practices. See page 469.

URINARY TRACT INFECTION
There is continuing controversy regarding imaging to identify abnormalities after urinary tract infection with discussion and debate about how intensively to investigate. Coulthard and colleagues compare guidelines from the Royal College of Physicians (RCP, 1991) with NICE guidance (2007). In essence the NICE guidance is intended to improve imaging efficiency by selecting higher risk cases. 427 children with confirmed first urinary tract infections were studied (2007) and followed through until 2011. Fewer children would have been examined according to NICE guidance (150 vs 427) although pick up urinary tract abnormalities was less (8 vs 32), with 5 of nine children with scarring missed, including 3 with multiple scars and one with renal impairment. It is interesting data. The decisions regarding investigation of urinary tract infection are complex and the authors advocate revision of the NICE guidance. See page 448.

MECONIUM ILEUS, CHOLESTASIS AND CHRONIC LIVER DISEASE IN CYSTIC FIBROSIS
The life expectancy for cystic fibrosis has improved considerably with median survival now approaching 40 years and with this there has been increased interest in non-respiratory complications such as chronic liver disease. Leeuwan and colleagues report the incidence and outcomes of cholestasis and meconium ileus from their unit (401 infants with cystic fibrosis presenting over 25 years, 69 with meconium ileus). Cholestasis occurred in 23/401, more commonly in infants with meconium ileus (27%) compared with 1.2%). Cholestasis resolved in all children. Longer term most infants with cholestasis (87%) and infants with meconium ileus (92.8%) did not develop cystic fibrosis associated liver disease with rates being similar to those seen in infants without meconium ileus or cholestasis. Although infants with meconium ileus have a significantly increased risk for the development of cholestasis this is not associated with an increased risk of liver disease long term. See page 443.

IMPROVING HEALTH CARE IN LOW INCOME COUNTRIES
It is a constant challenge to improve health care in low income countries with considerable effort devoted to developing new recommendations and technologies to improve hospital care. English and colleagues explore their adoption using data collected in a consistent panel of indicators during four separate cross sectional hospital surveys in Kenya tracking changes over the last 10 years. The data are of interest and show progress has been made with for example availability of specific feeds for severe malnutrition and availability of vitamin K although less progress has been made with facilities to monitor blood glucose, HIV testing and simple diagnostic/assessment tools like pulse oximetry. It is clear major gaps exist between potential and actual impact of simple diagnostics and technologies highlighting problems with availability, adoption and successful utilization. This sort of dataset is much needed. See page 452.

IN F&B THIS MONTH
There are a number of articles to highlight. Emond et al report the results of a randomised controlled trial of early frenotomy versus ‘normal’ care in breastfed infants with mild to moderate tongue tie. Primary outcome was breastfeeding at 5 days. The trial failed to demonstrate objective improvement in breast feeding but was associated with improved self efficacy (confidence in feeding, external observer’s evaluation of effectiveness of feeding). Many of the ‘normal care’ arm opted for frenotomy after 5 days. The findings are discussed in an accompanying editorial—The dilemmas of tongue tie—to snip or not to snip. There is further data from the EPICure 2 study. Marlow et al report perinatal outcomes for extremely preterm babies in relation to place of birth in England. Data is from a prospective cohort of births between 22 and 26 weeks gestation. Survival was significantly greater in specialist hospitals providing neonatal intensive care, further improved by higher activity services, although only 56% of births were in the setting (level 3 intensive care). Improvement was primarily achieved by a reduction in fetal deaths before delivery and in neonatal deaths in the delivery room and during the first week. This data has implications for the future planning of neonatal services—this is discussed in detail in the paper and two excellent accompanying editorials. The issue of ‘variation in outcome’ is explored from a different angle by Gallagher et al who report European variation in decision-making and parental involvement during preterm birth. This is an emotive and challenging topic. The authors report that there was little consensus as to how active involvement after birth at 22–25 weeks gestation is managed, with variable parental involvement and country being the biggest contributor towards whether or not active care is undertaken at extremely preterm gestation although I suspect there is also significant within country variation as well.