

SIDS: NEW RECOMMENDATIONS, NEW CONTROVERSIES

The American Academy of Pediatrics (AAP) recently released new recommendations regarding the prevention of sudden infant death syndrome (SIDS).¹ Among the 11 recommendations, the following are most controversial:

- Side sleeping is not considered as effective as supine sleeping in preventing SIDS and is no longer recommended
- Bed sharing may be hazardous, the AAP recommends a separate but proximate sleeping environment
- Use of a dummy at both nap time and bedtime should be considered after breast-feeding is well established

Why the new recommendations, why the controversy? First, there is increasing evidence, much of it from the UK, that certain factors in the infant sleeping environment are related to SIDS. For example, in this issue, Blair and colleagues explore the very complicated relationship between small at birth, side sleeping position, bed-sharing, and routine dummy use. Second, a recent meta-analysis that included seven studies that examined the relationship between dummies and SIDS found that there could be as much as a 50% decline in the rate of SIDS if all infants were given dummies (the authors estimate the number needed to treat as 1 for every 2733 infants).² Since most of these studies were conducted when supine sleeping was just becoming popular in the various countries in which the studies were conducted, I believe the results of the meta-analysis exaggerate the potential impact of the use of dummies. I suspect that many US parents are confused and some potentially angered by these recommendations. For the past two decades we have suggested that parents not use dummies – obviously, this is confusing. Many breast-feeding experts are concerned that the use of dummies may reduce breast-feeding rates. What of co-sleeping? The AAP has weighed in

on a common parent practice that is steeped in centuries of tradition. I am not certain that recommendations from any professional society will be able to influence certain cultural practices. In the words of one of my postgraduate trainees – a new mother – “has the AAP lost their mind?”

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THE CONSEQUENCES OF OBESITY

Sabin and colleagues, from Bristol, extend the findings of others, that obese children and adolescents have numerous metabolic abnormalities. They found that 10.3% of 126 children had impaired glucose tolerance and 59% had evidence of the metabolic syndrome. Surprisingly, they did not find that either impaired glucose tolerance or the metabolic syndrome was related to the severity of obesity. In a second report, from the ALSPAC group, Griffiths and colleagues report that obese children are significantly more likely to be both bullies and to be victims of bullying. Marilyn Augustyn, in an accompanying perspective, explores the relationship between bullying and power, but acknowledges that we know little about how power is defined and maintained by children.

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A DECADE OF EBM

The EBM movement is just over a decade old. The seminal editorial in *JAMA* in 1992 represented its coming out party; and the follow-up piece in *BMJ* in 1996 a restatement of its goals.^{3,4} Interestingly, the first piece was published in a US journal, although the home of the EBM movement is actually in Canada (McMaster) and the UK (Oxford). Although the US has “championed” EBM, our love of new technology, laboratory tests, and therapies, has made us a limited “consumer” of EBM.

Bob Philips provides a perspective on Archimedes – our attempt to make EBM practical and relevant. Very few people have the time or expertise to “Cochranize” a question. In addition, in paediatrics we often lack sufficient evidence to conduct a meta-analysis, but are still left needing to arrive at a clinical decision. Admittedly, Cochrane reviews, statements from NICE, meta-analyses, and formal guidelines are the cornerstone of EBM, but other forms of evidence are necessary. Archimedes is one such attempt at answering important questions.

EBM experts assure me that the movement has made a difference. Although I tend to agree, I have a hard time believing that prior to the 1980s we paid little attention to data, and practised by the “seat of our pants.” I am well aware of the numerous studies indicating the long delay before good clinical practice – based upon evidence – is adopted by many practitioners. On the other hand, is dissemination and adoption of new data any quicker now? If it is, has that occurred because of the EBM movement, or because of other changes in medicine? What of the desires of patients – in the most mature models of clinical decision making – patient choice – and not just evidence and physician knowledge and preference – is meant to influence clinical decision making.^{5,6} The challenge of EBM remains implementation and integration with patient choice.

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