



CrossMark

Highlights from this issue

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CONTROVERSIES IN THE DIAGNOSIS AND MANAGEMENT OF GROWTH HORMONE DEFICIENCY

Growth hormone deficiency is a rare cause of short stature (prevalence 1 in 4000). Although rare it is an important diagnosis to make correctly as therapy with growth hormone is highly efficacious and so a missed diagnosis will result in a poor outcome and equally a false positive diagnosis will lead to many years of daily subcutaneous injections, significant wasted expenditure and unnecessary exposure to potential adverse effects. In a comprehensive review, Murray and colleagues discuss the significant controversies in the diagnosis and management. Growth hormone stimulation tests play a key role in diagnosis but measured levels can vary significantly with the stimulation test and assay used. Different aspects of treatment are covered including starting dose (controversial), monitoring and when to stop treatment. At the end of growth a number of young people re test normal and it is not clear whether this reflects transient deficiency or a false positive diagnosis. This review is extensive and helpful and emphasises the importance of a careful and correct diagnosis and early reassessment if the growth hormone deficient child responds poorly to treatment with growth hormone therapy. There are useful sections of the article on when to consider growth hormone deficiency, how to investigate and practical summary recommendations on the diagnosis and management. *See page 96*

NEW MENINGOCOCCAL VACCINATION PROGRAMME LAUNCHED

Meningococcal disease is the leading infectious cause of death in early childhood, and its control has been a public health priority for decades. The immunisation programme has been a great success. Ladhani and colleagues report on recent developments—the introduction of an infant vaccine programme against meningococcal capsular group B (MenB) and the introduction of an adolescent programme against groups A, C W and Y. Immunisation against meningococcal capsular group C (MenC) was introduced in 1999 following a single clone outbreak and has sustained population protection against MenC for the last 15 years (figure

1) probably through herd immunity. These new vaccine programmes are exciting developments and in 2015 UK became the first country in the world to have a comprehensive routine meningococcal vaccine programme targeting all of the main capsular groups of *N. meningitidis*. The epidemiology, vaccinology, practicalities and future prospects are discussed in the paper—this is essential reading for all those who see patients who are unwell and in whom the possibility of meningococcal infection needs to be considered. *See page 91*

SHOULD THE UK INTRODUCE A UNIVERSAL CHILDHOOD VARICELLA VACCINATION PROGRAMME

Varicella is usually a self limiting disease but complications are commonly described. Varicella immunisation has shown good results in some countries but has not been universally implemented. Blumental and colleagues report data from Belgium by analysis of hospital admissions over a 12 month period. Inclusion criteria were acute varicella or varicella related complications up to 3 weeks after the appearance of the rash (552 children, median age 2, admitted to 101 hospitals, 97.7% of paediatric beds). The highest impact was in children 0–4 years (1.6/100 cases admitted), 65% had one or more complication justifying the admission—superadded bacterial infection (49%), neurological complications (10%), surgery (3%), paediatric intensive care (4%), mortality (0.2%). Interestingly only 14% had an underlying chronic condition. These data demonstrate a significant disease burden, particularly in the younger (and previously healthy) children, and are supportive of universal immunisation. The accompanying editorial discusses the important issue—should the UK introduce a universal childhood varicella vaccination programme? It is interesting to read through and reflect on the fact that the decision is by no means straightforward. *See pages 2 and 16*

CONFLICT IN A PAEDIATRIC HOSPITAL

Conflict in healthcare is well-recognised but under resourced. Forbat and colleagues report the frequency and characteristics of conflict in a paediatric hospital. The methodology is complex (see the paper). Data was recorded for the same

two 12 week periods in 2013 and 2014. The data informed semi structured interviews with key healthcare professionals. 136 individual episodes of conflict were reported with 25% reported as ongoing. The three most common causes were communication breakdown, disagreements about treatment and unrealistic expectations. Table two in the paper gives a fuller list. 448 hours of healthcare professional time was taken up with these complaints—most often from staff nurses, consultants, doctors in training and matrons. Most took up more than 3 hours of staff time. Conflict could be ranked as low, medium or high severity. Conflict was seen across all specialist areas most commonly neurology, general paediatrics and cardiology. The data emphasise the substantial impact on staff time and that training in conflict management (and support) should be offered to front-line staff. *See page 23*

THE MORBIDITY AND MORTALITY MEETING

Morbidity and mortality meetings are regarded as the cornerstone of the hospitals governance process. The format however varies widely and there is no agreed set model. James Fraser in a leading article gives his perspective proposing that the investigation of medical error, adverse events and child death each require a distinctive approach. The contentious issue of avoidability is addressed with an analysis of how proactive risk management should occur within a framework of clinical governance that achieves completion of a safety feedback cycle. The complexities of the RCA—Route Cause Analysis process are covered. Actions to complete safety feedback cycle the need to be ‘SMART’—specific, measurable, achievable, realistic, timely. The importance of being proactive rather than reactive is emphasised with the need for a culture of openness rather than over zealous accountability. The morbidity and mortality is an essential part of the modern NHS and should be a positive process embedded within a clinical governance process. The outcomes should impact on patient care and if required clinicians must not shy away from embracing change in the interest of their patients. *See page 4*