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# Highlights from this issue

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## I'VE GOT 99 PROBLEMS BUT A PHONE AIN'T ONE

Electronic health (e-health) is a broad term which encompasses electronic supported processes and communication in health care with the potential to impact positively on multiple different areas. This including medical record keeping, clinical decision support and coordination of care in many different health care settings. The massive international expansion in mobile connectivity has the potential to revolutionise access to healthcare in lower and middle income countries although this requires infrastructure and investment. Kumar *et al* report on two recent initiatives from Kenya where there are almost 38 million mobile phone subscriptions (population 44 million) and mobile phone subscriptions form 99% of all internet subscriptions. The first is an attempt to create a scalable clinical decision support system supported by a global network of specialists including many clinicians born in Kenya and now working overseas. The second effectively extracts digital information from paper based records using low cost and locally produced tools such as rubber stamps to improve adherence to clinical practice guidelines. These initiatives bring down the costs of remote consultations and clinical audit and offer the potential for clinics in resource limited settings to deliver high quality care. It is interesting to read. The challenges are relevant to all health care settings. The authors rightly make the case for continued and increased investment in such initiatives that bridge academia, public and private sectors to deliver sustainable and scalable e-health and mobile-health solutions. *See page 974*

## SELECTING CHILDREN FOR CT FOLLOWING HEAD INJURY

There are specific National Institute of Health and Care Excellence (NICE) guidelines in place for when to request a CT scan in a child who presents with a head injury (2007, revised 2014). Kemp *et al* report uptake, influential variables and yield (children <15 years admitted for more than 4 hours following a head injury, 5700 children over 6 months). CT scans were performed on 30.4% (1734) with a higher diagnostic yield in infants (144/255) than children aged 1–14 years (391/1476). Based on the 2007 guidance only 40.4% of children who fulfilled at least one of the four NICE criteria (Glasgow coma scale <15 for an infant or <14 for an older child, loss of consciousness, a dangerous mechanism of injury, suspicion of non accidental injury) for CT actually underwent one. Children who fulfilled NICE criteria were

more likely to have a CT scan if admitted to a specialist centre, or age >3 years. There was considerable variation between hospitals and between regions. The low and variable compliance with guidance requires further consideration with the potential risks being of missing serious intracranial pathology but also the overuse of specialist imaging in children who present with head injury. The authors discuss the more recent 2014 guidance which includes a second tier of indicators which permit a 4-hour observation followed by CT if the child deteriorates and may be more appropriate and is consistent with data presented. There is clearly more research needed to better inform the best investigative approach in children who present with head injury. *See page 929*

## FAMILY INCOME AND YOUNG ADOLESCENTS PERCEIVED SOCIAL POSITION: ASSOCIATIONS WITH SELF-ESTEEM AND LIFE SATISFACTION

This is an interesting paper to consider. Self-esteem and life satisfaction are important aspects of positive mental health in young people, and both are socially distributed. It is likely that as children enter adolescence and gain independence perceptions of their own social position are likely to influence their mental health. Bannik *et al* use data from the UK Millennium Cohort Study to investigate the association of family income in young adolescents (11 year olds) and their social position with self-esteem and life satisfaction. The methodology (proportional odds, odds ratios) and data are in the paper. In summary the likelihood of greater self-esteem and life satisfaction increased with income and similarly the risk of having poor self-esteem and life satisfaction was greater in those with the lowest income. The perceptions of young people were important. Young people who perceived their families as poorer than their peers (rather than the same) had lower self-esteem and life satisfaction. This was also true of young people who perceived their families to be richer than their peers who also had lower self-esteem and life satisfaction. This effect was independent of household income. It is of interest and challenging to see how we might impact on it particularly as we are aware that inequalities in self-esteem and life satisfaction are likely to persist into adult life. *See page 917*

## CLINICAL PRESENTATION OF CHILDHOOD LEUKAEMIA

Leukaemia is the most common cancer of childhood accounting for a third of cases

with 450 new cases per year in the UK (4000 in the USA). The presenting features are not always typical. Clarke review the literature—33 studies, 3084 children. Common features at presentation included hepatomegaly (64%), splenomegaly (61%) pallor (54%), fever (53%) and bruising (52%), recurrent infections (49%), fatigue (46%), limb pain (43%), hepatosplenomegaly (42%), bruising/petechaie (42%), lymphadenopathy (41%), bleeding tendency (38%), rash (35%). Abdominal symptoms were common including anorexia/weight loss (29%), abdominal pain (12%) and distension (11%). Mucosal bleeding was seen in 25%. The authors discuss the implications for practice. Many patients have multiple features at presentation. Features such as fever, pallor and fatigue occur in many childhood illnesses—others such as hepatomegaly, splenomegaly, lymphadenopathy and petechaie are more specific and therefore more useful as red flags. In essence though any child who presents with an unexplained illness warrants a careful clinical examination including abdominal palpation, examination for lymphadenopathy and careful scrutiny of the skin with consideration of leukaemia as the potential diagnosis. There is an excellent accompanying editorial—When should I suspect childhood leukaemia? *See pages 894 and 874*

## UPDATE ON CARBOHYDRATES AND HEALTH

In July 2015 the Scientific Advisory Committee on Nutrition (SACN) published their report on carbohydrates and health which provided recommendation to the UK government on the population intakes of carbohydrates, sugars and fibre in the UK. The methodology, evidence base, findings and implications for children are reviewed in this issue. There has been no change in the recommendation that approximately 50% of energy intake should be derived from carbohydrate. There are specific recommendations relating to 'free' sugars (explained in the paper) which should be no more than 5% of energy intake and sugar sweetened beverages which should be minimised in children and adults. The evidence for these recommendations are discussed. The definition of fibre is reviewed and pragmatic recommendations for intake made. In the context of childhood (and adult obesity) and the risk factors and consequences the paper is essential reading particularly the sections on current intake, dietary patterns and what needs to change. *See page 876*