Atoms

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INTRODUCING BNF-C FOR CHILDREN

It is with a great deal of excitement that the British National Formulary for Children (BNF-C) is introduced. A product of two groups—the British National Formulary team and the group that produced the Medicines for Children books—this publication is meant to be the definitive guide for all doctors, pharmacists, and dental practitioners who care for children. It will follow the same format as the BNF and an electronic PDA version is promised by Autumn 2005.

See page 997

IDENTIFYING COMORBIDITY IN CHILDREN WITH ADHD

About one third of children with attention deficit hyperactivity disorder (ADHD) have significant comorbid conditions, such as depression or obsessive compulsive disorder, that complicate treatment. Whereas there are numerous standardised forms that help diagnose ADHD, they generally do not identify other problems. Biederman and colleagues from Boston, report the utility of the Child Behavior Checklist (CBCL) as a screening tool to identify children with conduct and bipolar disorders, major depression, and multiple anxiety. They found that the scores on the delinquent and aggressive behaviour scales can be used to identify these disorders. They report sensitivity, specificity, and positive and negative predictive values. Since their sample is drawn from a referral population, with a high prevalence of comorbid conditions, the positive predictive value and negative predictive value that they report are likely different than those that would be obtained in a nonreferral population. Regardless, given the importance of identifying children with comorbid conditions, particularly if our pharmacological armamentaria improves, this is an informative study.

See page 1010

DISTURBING RATES OF OBESITY

Stamatakis and colleagues from University College present comprehensive data about overweight and obesity trends from 1974 to 2003 in English children. The data are disturbing, but not surprising. They mimic information from many other countries. For example, the rates of obesity for boys aged 5–7 years increased from 1.0% in 1974 to 5.2% in 2002–03. For obesity, there was a five to six fold increase for all groups (boys and girls aged 5–7 and 8–10 years), and a near doubling in the prevalence of overweight children (18.5% to 27.1%). Sadly, the rate of change was substantially greater between 2000–01 and 2002–03 than between 1974 and 2000. In a companion perspective, Rudolf, Hochberg, and Speiser describe the conclusions of a recent International Consensus Statement on childhood obesity. The statement addresses definition, preventive strategies, screening, assessment, and treatment. The authors discuss the implications of this statement for the UK.

A recent brouhaha occurred in the US with respect to screening children for obesity (*Pediatrics*, July 2005). Because of the lack of evidence regarding the effectiveness of behavioural counselling for overweight children in the primary care setting, the US Preventive Services Task Force (USPSTF; an independent panel of experts in prevention and primary care that systematically reviews evidence) concluded that there is insufficient evidence to recommend for or against routine screening for obesity in children. There are two commentaries in the same issue of *Pediatrics* that take issue with the statement from the USPSTF. Will we be successful in reducing the rates of obesity among children living in developed countries? I think so – I have been impressed with the various responses of government, parents, schools, and industry to this epidemic. The average body mass index (BMI) for children will fall over the next decade. I am less optimistic that weight management programmes for morbidly obese children will be successful.

See pages 994 and 999

AUDITS, PUBLISHING, AND DIABETES

The report from Edge and colleagues from the Radcliffe Hospital raises many points. First, what audits should we publish in *ADC*? This is a constant source of debate at our biweekly auctions. In general, multi-site audits of more common diseases, particularly those in which national standards have been developed, will be more favourably reviewed. Second, should we keep publishing updates from the same group? Our feeling is no, other platforms for these reports will need to be found. Finally, what of the content of this article? It is clear that over the 14 year period of these audits (1988 to 2002), fewer consultants, but with greater expertise, now care for children with diabetes. The response rate declined only 8%, but the number of respondents declined more substantially from 360 to 187. There appears to be more expertise in clinics – diabetes specialist nurses, and paediatric dieticians are far more common in 2002 than 1988. The regular measurement of haemoglobin A1c remains high. These results are interesting, but represent process measures of care, not health outcomes. Are children with diabetes better off today than in 1988? Do they have fewer complications, live longer, and are they hospitalised less frequently? Those are the outcomes we should report.

See page 1005

IDENTIFYING CHILDREN WITH STREP THROAT

Rheumatic fever and rheumatic heart disease are uncommon in high income countries. In low and middle index countries, rheumatic heart disease (RHD) is still a major cause of morbidity and mortality. The World Health Organization (WHO) was very successful in developing a clinical prediction rule for bacterial pneumonia. In a multi-site trial conducted in Brazil, Croatia, and Egypt, Rimoin and colleagues report the evaluation of the WHO clinical decision rule for streptococcal pharyngitis. Unfortunately, the rule performed poorly – with a sensitivity ranging between 3.8% and 10.8% in children older than 5 years and 0.0% to 4.6% in younger children. These investigators are to be congratulated. The development of clinical prediction rules is complicated, involving the derivation of the rule, its validation in a clinical setting, and then validation in new settings with different clinicians. Unfortunately, predicting who has streptococcal pharyngitis is not nearly as easy as predicting who has pneumonia.

See page 1066

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