



CrossMark

Highlights from this issue

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DOES SEXUALLY TRANSMITTED INFECTION ALWAYS MEAN SEXUAL ABUSE IN YOUNG CHILDREN

Sexually transmitted infections are an uncommon but recognised consequence of sexual abuse among young children. There is agreed guidance for assessment and management. Reading and colleagues report the incidence, mode of presentation, investigation and child protection procedures in children under between age 1 and 12 years presenting with common (non viral) sexually transmitted infections (British Paediatric Surveillance Unit, 25 months, 2010–12). Fifteen cases were reported—Gonorrhoea (7), Syphilis (1), Chlamydia (6), Trichomonas (1). This gives an overall incidence of 0.075 cases per 100,000 per year. Five cases presented with ophthalmic infection. Sexual abuse was confirmed in three by court or case conference and was suspected in a further seven children. Most cases were identified following symptomatic presentation. In an accompanying editorial Patrick Kelly discusses the data suggesting that the incidence may be an underestimate as the following assumptions were made to calculate—children with genital symptoms were brought for medical contact, their symptoms were adequately assessed, samples were taken and processed correctly and positive samples were notified to a paediatrician and the surveillance unit. He also addresses in some depth the emotive question—Does sexually transmitted infection always mean sexual abuse in young children—essential reading for paediatricians. *See pages 712 and 705.*

ASSESSMENT AND MANAGEMENT OF SHORT (AND TALL) STATURE

Short stature is common and paediatricians need a clear strategy for the assessment and management. It is important to recognise what is 'normal'. Most pathological causes will be associated with clues in the history or examination. Cheetham and Davies present an evidence based update and practical strategy for dealing with such cases including factors that should trigger a more detailed assessment (malaise, dysmorphic features, slow growth, small size with normal weight gain) and how to establish that the healthy short child is growing appropriately for their family size—potentially reassuring for the child, family and clinician. In an accompanying review the same authors discuss the assessment and management of tall stature—much less common, mostly familial although with a series of rare disorders which need to be considered and will, on occasion, require specific treatment. The paired reviews are

editor's choice this month and are a useful and practical update on growth disorders in childhood. *See pages 767 and 772.*

CHARTING THE TERRITORY: SYMPTOM AND FUNCTIONAL BURDEN IN CHILDREN WITH PROGRESSIVE, NON-CURABLE CONDITIONS

There are increasing numbers of such children—children with progressive, non curable genetic, metabolic or neurological conditions who require specialist care to enhance their quality of life. Steele and colleagues report the symptom burden from a prospective cohort (275 children and their families, parent and clinician, multi-centre). It is pretty sobering reading. The patient group is complex. Most have a significant symptom burden. The three most commonly reported symptoms were pain (55% parents, 26% clinicians), sleep problems (50% parents, 29% clinicians) and feeding difficulties (48% parents, 41% clinicians). Clinicians under reported symptoms compared with parents. Regardless of medications (many were on multiple) pain, feeding difficulties and constipation were common and distressing. Children with gastro-jejunal tubes were the most symptomatic, generally having the most severe disability. The challenges from a data set like this are multiple—can we better control symptoms, do the various interventions need more evidence of efficacy, why the mismatch between clinician and parental reporting, is it reasonable to expect to control these symptoms completely, how do we best assess and improve quality of life for this vulnerable patient group. *See page 754.*

PARENTAL PERSPECTIVES ON THE EVALUATION AND MANAGEMENT OF FEVER IN YOUNG INFANTS

Persistent or high fever resulting in admission to hospital will usually trigger extensive investigation to rule out serious bacterial sepsis. De and colleagues report the perspectives of 36 parents (27 infants admitted <3 months, full septic screen, antibiotics, favourable outcome). In some respects the findings are not surprising—parents felt very vulnerable, fear the possibility of severe illness, experience a sense of helplessness and loss of control. Parental empowerment was key to the themes that emerged. Parents value interactions that inform, support and involve them during the course of medical investigation/management. Significant potential barriers to this can exist and are discussed in detail in the paper. This should

prompt us all to reflect on our practice. The article (table 4) lists key challenges for parents and suggested strategies for the clinician to deal with them promoting empowerment and partnership during the infant's acute illness episode. There is an impressive accompanying editorial written by a parent. *See pages 717 and 706.*

LIVING WITH TEENAGERS

Social disadvantage is associated with elevated parenting stress and lower rates of uptake, higher dropout rates and poorer outcome in conventional parenting programmes. A peer led parenting intervention—EPEC (Empowering Parents, Empowering Communities) has been successfully implemented with socially disadvantaged parents of 2 to 11 year olds. Adolescents can be more challenging and there is less evidence of efficacy of such interventions. Michelson and colleagues test the feasibility of a peer-led parenting intervention for parents of adolescent children. The intervention was a structured group based session (living with teenagers) delivered by trained peer facilitators. Participants were parents seeking help. Feasibility was assessed in terms of uptake and completion rates (42 parents, 79% from minority ethnicity backgrounds, almost 50% lone parents; 71% completed more than 5 sessions). Significant changes were observed in reduced parental concern, increased parenting satisfaction and less negative expressed emotion. The intervention was well received with high uptake among traditionally hard to reach parents with the potential to impact on attitudes, behaviours and outcomes for vulnerable families struggling to deal with difficult adolescents. The authors acknowledge the limitations of the study—observational, no evidence of impact on the teenagers and recommend further research including controlled trials to assess potential long term impact. *See page 731.*

IN EDUCATION AND PRACTICE THIS MONTH

There is an excellent review of the evidence-based recommendations for the diagnosis and treatment of acne published by the American Academy of Paediatrics (*see page 135*). This includes a summary of the guidance with helpful and practical pointers to influence practice including what should I stop doing, what should I start doing, what can I continue to do as before, what should I do differently and then unresolved controversies with a clear clinical bottom line regarding how best to treat.