

Education & Practice: the debut of a new section

Since the launch of *Education & Practice* four years ago, we have tried to add new sections that focus on clinical care. Both Dermatophile and Illuminations reflect our desire to expand and diversify our offerings—both dermatology and radiology are important parts of paediatric care. Over the past year, Ian Wacogne, a consultant paediatrician from Birmingham, and an Associate Editor, who has also spearheaded our RSS feeds and blogs on *ADC*, has worked diligently to develop yet another new section—Interpretations. This section will focus on new diagnostic tests, both those that are traditionally laboratory based, such as tests for allergy or coeliac disease, as well as those that are less common—for example, questionnaires for attention deficit hyperactivity disorder (ADHD). In this issue, Carter and Syed-Sabir review various surveys that can help in the diagnostic evaluation of children with suspected ADHD. If you have any suggestions for Ian, feel free to contact him at ian.wacogne@googlemail.com.
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Autism and MMR: letters, a response and the original article

In February 2008 we published, ahead of print, an article by Gillian Baird and colleagues that assessed the relationship between measles vaccination and autism spectrum disorder (ASD). In a community sample of children with ASD (n = 98), a group with who required special educational needs (n = 52), and a third group who were developing normally (n = 90), they found no relationship between cases and the two control groups in measles antibody or in measles virus nucleic acid amplified by reverse transcriptase—PCR in peripheral blood mononuclear cells. Immediately after this article was published ahead of print, we received numerous “letters to the editors.” We asked Dr Baird to respond, and because of the importance of the issue, the original article, letters to the editor and author response are all published in this issue. **See pages 832, 905, 906 and 907**

Decision making when there is no evidence

It is estimated that there is good evidence for about one third of our decisions. Numerous groups have championed new approaches to evidence-based medicine when high quality studies, such as randomised clinical trials or meta-analyses are lacking. In this issue, Drs Keen, Fonseca and Wintgens, from St Georges, describe a care pathway for children with selective mutism. This is not published as a review, but rather as original research. They utilised an increasingly popular technique, termed the modified Delphi approach, to develop this pathway. The Delphi method was first developed by the RAND Cooperation in California to assist the US military in understanding the impact of various war scenarios on the survival of the US population; it has now been modified to assist in clinical decision making. The modified Delphi approach involves culling, reviewing and ranking any evidence related to a particular issue, and then presenting it to a group of experts. Two rounds of independent ratings of quality indicators or other specific statements are involved with a face-to-face discussion between the rounds. During the meeting, the experts can modify, add or delete quality indicators. To be included, an indicator needs to be valid, feasible and the rating consistent (without strong disagreement) among the experts. The ones with disagreement are presented to the experts during the face-to-face meeting for discussion. Why is the modified Delphi process considered better than simply having experts develop an opinion paper? First, experts may not be aware of all of the data, and in the scenario described above they all start with the same understanding of the evidence. Second, by getting a chance to rethink (and rerank) their opinions, they clearly can be influenced by the opinions of their peers. This allows for “peer influence,” but minimises the likelihood that a single person can unduly influence the group. Finally, this reiterative process is considered superior to a one time meeting in which participants cannot reflect upon their opinions. This process has been used extensively to develop numerous quality indicators for both adult and paediatric primary care.^{1,2}
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Evaluation for sexual abuse: timing makes a difference

There is an important paper by Watkeys and colleagues, from the Department of Child Health, Swansea is this issue. They examined the likelihood of a positive result on physical examination—signs consistent with sexual abuse based upon a well-recognised classification system—in children who were referred by the police or social services for examination because of concern of sexual abuse. This study has numerous strengths. It includes a large number of children—331. The examinations were all conducted by four paediatricians trained in forensic examination. The study period was recent—July 2002 to December 2005. Lastly, the examiners were unaware of the study question—that is, what is the influence of the timing of the medical examination on the likelihood of a positive finding. The results suggest that both “pubertal and post-pubertal girls are more likely to have significant signs if they are examined within 7 days of the last episode of sexual abuse.” These findings do make inherent sense. However, it is also likely that when the authorities had greater concern for sexual abuse they brought these children in sooner for examination. Unfortunately, the authors could not control for “severity of complaint.” However, they have done an exceptional job in trying to account for timing of examination, age (pubertal versus not pubertal), and type of complaint (vaginal versus anal penetration). **See page 851**

This month in *Education & Practice*

The offerings include our new section, Interpretations (**see page ep159**), as well as a best practice (*Medulloblastoma: new insights into biology and treatment*, **see page ep137**), a problem solving case (*Changing colours*, **see page ep145**), a pharmacy update (*Drug use in acute meningococcal disease*, **see page ep151**), and a guideline review (*Autism spectrum disorders*, **see page ep163**).

REFERENCES

1. McGlynn EA, Asch SM, Adams J, *et al*. The quality of health care delivered to adults in the United States. *N Eng J Med* 2003;**348**:2635–45.
2. Mangione-Smith R, DeCristofaro AH, Setodji CM, *et al*. The quality of ambulatory care delivered to children in the United States. *N Eng J Med* 2007;**357**:1515–23.