

# This Month In **The JOURNAL** of **PEDIATRICS**

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## Database linking and Audioslides

— Monica L. Helton, BA  
— William F. Balistreri, MD

*The Journal* continually seeks content innovations that complement published articles while adding value for readers. In November 2015, *The Journal* added database linking as an option for authors who would like to make their databases available to readers (<http://www.jpeds.com/content/authorinfo#data>).

We now have implemented Audioslides (<http://www.jpeds.com/content/authorinfo#audio>). These brief, webinar-style presentations accompany published articles on [jpeds.com](http://www.jpeds.com) and ScienceDirect to put the article in context, in the authors' own words. Beginning in April 2016, authors of accepted manuscripts automatically receive an e-mailed invitation to create an AudioSlides presentation. Audioslides are not peer-reviewed, but the Editors will review all Audioslides for accuracy; presentations that inflate or "spin" the article's findings will be removed at the Editors' discretion.

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## Lest we forget — the battle against malnutrition

— Carlos A. Cuello-Garcia, MD

We are now living in an era of postmillennium development goals and, although a significant number of them have been completed, a significant proportion of targets remain to be accomplished. Malnutrition is still a concern that affects millions worldwide. In this issue of *The Journal*, Chowdhury et al present a large scale population-based survey in Bangladesh, extracted from the Bangladesh Demographic Health Survey (2011). This could be considered a large and representative sample of a region where prevention of malnutrition is (and it should be kept as) a priority as a public health intervention. This study shows that there are still important factors (some of them modifiable) related to malnutrition in growing economies, such as parental education, socioeconomic and community status, religion, region of residence, and food security. Although these and other factors are well known to many of us, the importance of this report relies on its effect on our collective memory to not lower our guard on the issues that are proven to improve global health outcomes and better opportunities for development. This could be relevant for specialists in child nutrition and public health.

Article page 194 ►

## Pay attention to when children start school!

— Paul G. Fisher, MD

Is there a growing worldwide epidemic of attention-deficit hyperactivity disorder (ADHD)? Prevalence rates of up to 15% have been reported in Western countries (*World Psychiatry* 2003;2:104-13). This rise could be due to a true increase, more intensive case ascertainment, or overdiagnosis.

Previous research has conflicted on how much the relative age of a child at school entry contributes to diagnosis. In this issue of *The Journal*, Chen et al examine cohort data obtained from 378 881 children ages 4 to 17 years followed in the Taiwan National Health Insurance Database from 1997 to 2011, and they determine odds of diagnosis of ADHD or its treatment based upon relative age. Comparing children born in August (the Taiwanese cutoff birthdate for school entry is August 31) with those born in September, the investigators found that the children born in August had precise,

statistically significant, and robustly elevated odds ratios for being diagnosed with ADHD and receiving medication. Thus, relative age, which may be a proxy of neurocognitive ability, plays into the diagnosis of ADHD and perhaps its overdiagnosis.

We should note that this study now documents the variable prevalence of ADHD diagnosis and treatment in an Asian country. All clinicians and parents worldwide should pay careful attention to the relative age of a child compared with classmates when a diagnosis of or treatment for ADHD is being considered. Immaturity is not the same as ADHD.

[Article page 162 ►](#)

## Kids clot, too—just not like adults

— William S. Ferguson, MD

**M**uch of our practice regarding venous thromboembolism (VTE) in children is extrapolated from adult data—less than optimal given the pediatrician's refrain that "children are not just small adults." The relative rarity of VTE in children has certainly contributed to this lack of knowledge. In this issue of *The Journal*, Sabapathy et al report on their analysis of 11 years of data on pediatric VTE extracted from the Quebec health care databases, which provided a large and robust population-based data set. The current report is comparable in both scope and methodology with an earlier report covering all age groups from the same researchers.

As expected, the incidence of VTE among children (0.29 VTE per 10 000 person-years) was much lower than for adults (approximately 12 per 10 000 person-years overall, climbing exponentially with increasing age). The incidence was especially low throughout early childhood (0.03-0.04 per 10 000 person-years for ages 1-10 years). Whereas the major risk factors for thrombosis—cancer, surgery, presence of a central venous catheter—were similar to those found in adults, only one-half of cases had an identifiable risk factor, a rate lower than previously reported for either children or adults. Other differences included a higher incidence among females compared with males (even prior to puberty) and a lower death rate. Although the 6.4% all-cause mortality in this cohort is not trivial, by comparison 20% adults diagnosed with VTE die within 1 year.

Over the past few decades, pediatricians have become much more aware of the risk of VTE, especially among critically-ill, hospitalized patients. Still, the finding that one-half of patients who were diagnosed with VTE had no identifiable risk factor suggests that we may still be missing cases. VTE is not only associated with substantial risks of subsequent morbidity and mortality, but is also amenable to treatment and prevention. This should prompt all of us who care for pediatric patients to keep the possibility of VTE in mind, especially for those whose underlying condition does not fit into the groups classically felt to be at risk.

[Article page 175 ►](#)

## Perinatally-acquired herpes simplex virus infection and empiric acyclovir therapy

— Sarah S. Long, MD

**A**dministration of acyclovir empirically in very young infants coming to medical attention with nonspecific (usually febrile) symptoms is gaining a foothold in the US, predominantly because increased mortality has been associated with even a 1-day delay in therapy of herpes simplex virus (HSV) infection. Narrowing use of acyclovir to a particularly at-risk group of infants having this uncommon infection would be ideal. In an attempt to add granularity to characteristics of infants infected with HSV, authors from children's hospitals in St Louis and Salt Lake City compiled cases of 49 infants admitted over 11 years.

Most (88%) infants with HSV came to first medical attention  $\leq 28$  days of age. The majority had classic signs of HSV disease but 16% had only nonspecific symptoms. The latter group were either  $\leq 14$  days of age or had cerebrospinal fluid (CSF) pleocytosis or both. The few patients coming to attention after 28 days of age had overt symptoms and signs of HSV central nervous system (CNS) or skin-eye-mouth disease.

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