

This Month In **The JOURNAL** of PEDIATRICS

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Welcoming a new Associate Editor to *The Journal*

— William F. Balistreri, MD

It is with regret but warm wishes that I announce that Alan H. Jobe, MD, PhD, will be stepping down from his Associate Editor role at the end of 2015. Dr Jobe played, and continues to play, a pivotal role in making *The Journal* the “go to” journal for high-impact neonatology research. Despite his personal “10-year rule” (“after 10 years for any academic position, new leadership should come from someone else—preferably younger—who is given the opportunity”), he has broken this rule and continued as an Associate Editor for 18 years “because I have very much enjoyed serving as a referee for some of the best research in neonatology that is being submitted to *The Journal*.”

Dr Jobe plans to expand his involvement in international research through the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development Global Research Network. He will continue with active animal model research programs focusing on antenatal corticosteroids, fetal inflammation, and prematurity in association with colleagues at the University of California Davis National Primate Research Center and at the University of Western Australia, and will remain active both clinically and with teaching. Although Dr Jobe will be missed as an Associate Editor, we are pleased that he will continue his relationship with *The Journal* by serving as an Editorial Board member beginning in 2016.

With the approaching departure of an Associate Editor, we started the search for a new Associate Editor to join *The Journal's* leadership. After assessing outside candidates as well as the pool of current Editorial Board members, we have chosen someone who we believe will continue to attract high quality neonatology research to *The Journal* and who will excel as an Associate Editor.

We would like to welcome and introduce Robin H. Steinhorn, MD, as *The Journal's* newest Associate Editor. Dr Steinhorn began handling new manuscripts in September.

Robin H. Steinhorn, MD, joined Children's National Medical Center in September 2015 as the Senior Vice President for Hospital Based Specialties. Prior to arriving at Children's National, she served as Chair of the Department of Pediatrics at the University of California Davis and Pediatrician in Chief for the UC Davis Children's Hospital. Dr Steinhorn is a member of the Council of the American Pediatric Society and serves on the American Board of Pediatrics for Neonatal Perinatal Medicine. She is an elected Fellow of the American Heart Association and a member of the Perinatal Research Society and American Thoracic Society.

Dr Steinhorn's clinical and academic interests have primarily been focused on the pulmonary vascular development of the fetus and newborn. Her translational work has spanned from in vitro studies to animal models, and she has contributed to numerous multicenter trials that have helped define the clinical treatment of pulmonary hypertension in the neonatal period. Her recent clinical research also has addressed telemedicine support of neonatal care in rural hospitals. She is married to a pediatric intensivist and has two children pursuing medical careers. She looks forward to carrying on Dr Jobe's legacy of publishing high-impact neonatal research in *The Journal*, and continuing to support trainees and young investigators as they navigate presenting and publishing their research findings.



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Got shunt. Need CT?

— Paul G. Fisher, MD

Any physician who has taken call in the emergency department (ED) knows that children with ventriculoperitoneal shunts present often with fever, lethargy, or other complaints, and then pose a dilemma about whom should undergo evaluation for shunt failure with head computed tomography (CT). Are we needlessly irradiating some children with repetitive head CTs?

In this issue of *The Journal*, Florin et al utilize the Pediatric Health Information System database from 31 children's hospitals to examine what happened over the next 10 years to a cohort of 1319 children following initial shunt placement when they presented to the ED.

Nearly one-half of all ED visits for these children were associated a head CT. The rate of CT among these patients varied widely and significantly across hospitals and was also associated statistically with the principal, underlying diagnosis. Perhaps most striking was the finding that just under 6% of the children accounted for close to 40% of all ED visits coupled with a CT. These patients received cumulatively ≥ 10 CTs. However, these children were least likely to undergo a shunt revision.

Clearly we have much work ahead of us to remedy this mismatch. Not only do we need better ways to improve our sensitivity and specificity in the use of CT to identify children with shunts truly needing repair, but also we need to find ways to "shunt" these high-risk children to radiation-sparing rapid sequence brain magnetic resonance imaging (MRI) rather than radiation-based CT. Few children in this study underwent rapid MRI. The finding that nearly 1 in 6 of the children undergoing CT were exposed to cumulative radiation dose >20 mSV, linked with a risk of cancer, cannot be condoned. Moreover, because 4 of the 5 children undergoing CT did not require a revision, we need to refine better who needs imaging and then find a way to make these MRIs.

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Quality of life may not reflect quality of sleep

— Denise M. Goodman, MD, MS

In this issue of *The Journal*, a small clinical study assessed the residual psychosocial impairments of sleep disordered breathing (SDB), comparing those with and without sleep symptom resolution and healthy controls. Patients were examined at ages 3-5 years and again at ages 6-8 years. Outcomes included health-related quality of life, general quality of life, family functioning, and parental stress, and formal polysomnography was performed at both time points. Health-related quality of life using a sleep-specific instrument, the OSA-18, showed poorer quality of life for those with sleep disturbance compared with controls, and there was no difference between those for whom SDB had resolved vs those with unresolved SDB at follow-up. This observation held despite some improvement at follow-up compared with baseline measures. For many aspects of general quality of life, there was no difference between groups with unresolved and resolved SDB, with the exception of family social functioning, which was poorer in the resolved group than the unresolved or control groups. Improved obstructive apnea hypopnea index (OAH) was associated with better school performance, less family worry, and improved family relationships. Lastly, most aspects of parental stress did not change between baseline and follow-up, regardless of whether SDB resolved.

For many domains, psychosocial functioning at ages 6-8 years was poorer for those children diagnosed with SDB at ages 3-5 years than for controls, even if the SDB resolved by ages 6-8 years. That said, any improvement is likely related in part to disease severity.

It is not possible to dissect whether this is because early SDB has an irreversible developmental affect, or rather that behavioral difficulties were the principal drivers of psychosocial issues such that resolution of the respiratory symptoms has no influence on psychosocial outcomes. Importantly, these data add to growing recognition that improvements in polysomnography do not necessarily translate to improvements in important psychosocial outcomes. Conversely, even mild disease may have long term affects, meriting close follow-up throughout childhood.

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