

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

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## Will you listen to my concerns about autism?

— Paul G. Fisher, MD

**W**e already know that children with autism spectrum disorder (ASD) manifest symptoms before age 2 years, and their diagnosis can often be made confidently before age 3 years. There is consensus too that multimodality therapy sooner than later is the intervention of choice to optimize their developmental outcomes.

Do pediatricians and other health care providers react proactively to parental concerns about their child possibly having autism? Using data from the nationally representative Survey of Pathways to Diagnosis and Treatment, Zuckerman et al examined retrospectively the parent experiences among 1420 children with ASD and 2098 comparison children with nonspecific intellectual disability/developmental delay (ID/DD). The authors determined child's age when parents first had concerns about development, child's age at first discussion of concern with a provider, provider's responses to the concern, and, among children with ASD, child's age at diagnosis according to the parent. On average, parents first had worries about ASD at age 2.1 years and ID/DD at age 3.1 years, even though they first discussed their concerns with a health provider at 2.3 and 3.2 years of age, respectively. However, parents reported initially being told their child had ASD at an average age 5.2 years. Parents with concerns about ASD were more likely to receive reassuring passive responses than those who raised concerns about ID/DD, and such passive remarks were associated with a longer time to diagnosis of ASD.

As pediatricians, we hear parents say all sorts of things. We always need to listen to their concerns. Do we worry about saying the "A" word? In my own practice, I always have been struck by how grateful parents are when directly asked, "Are you concerned about autism?" No parent has ever resented that question. We need to take that more proactive approach with any developmental delay in language, social skills, cognition, or fine and gross motor skills.

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## Weight management involves more than weight loss

— Stephen R. Daniels, MD, PhD

**I**t has been common wisdom to think that the main adverse issues related to obesity derive from excess fat mass and that the target for intervention in obesity should be to reduce the amount of adipose tissue. However, in clinical practice, it seems potentially more complex than that. As patients in weight management programs are tracked, some lose weight, improve their body mass index (BMI) percentile, and improve cardiometabolic risk factors. However, other patients who change their diet and increase their physical activity appear to improve their cardiometabolic risk factors without change in weight or BMI percentile. How can this happen?

In this issue of The Journal, Browning et al explore these issues. They evaluated changes in fat mass, fat-free mass, and cardiometabolic risk factors during a 6-month lifestyle intervention. They compared those who lost weight and those who gained weight while in the program. They found improvement in cardiometabolic risk factors in both groups. In the group that gained weight, fat-free mass increased, as well fat mass, so the percent of body fat was unchanged. These results emphasize that changes in lean body mass may be as important as changes in fat mass in a weight management program. These results have implications for how we counsel patients as they progress through a weight management program. We need to emphasize that there is more to evaluate than weight loss alone.

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## Sunscreen use matters

— Paul G. Fisher, MD

Previous research has demonstrated increasing long-term incidence of pediatric melanoma from 1973 to 2009, particularly among teens. In this issue of *The Journal*, Campbell et al report a study of melanoma incidence in patients 19 years of age and younger from 2000 until 2010, based upon the Surveillance, Epidemiology, and End Results cancer registry. These investigators found a significantly decreasing trend from 2004 through 2010, especially in melanoma arising on the trunk or upper extremities. Declines were most notable in adolescents 15 to 19 years of age.

Why are these decreases occurring? The decline could be related to improved sun protective behaviors, such as wearing hats and shirts, as well as use of sunscreen. Another less sanguine hypothesis is that our children are spending more time indoors with televisions, computers, and other electronic devices. Since the time period studied, nearly all states have now passed laws restricting the use of tanning beds by minors, and perhaps trends will change more. Further monitoring of melanoma occurrence is warranted, but in the interim, the aphorism “wear sunscreen” continues to be good advice.

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## Yogurt and health

— Thomas R. Welch, MD

The medical and lay literature is replete with studies of probiotics and their potential effects on health. Indeed, there are so many studies of this topic that journals such as ours need to be rather selective in choosing them.

The current issue of *The Journal* contains a rather unique study of this topic, with intriguing results. Ringel-Kulka et al report a study of healthy children in a day care center who received a daily dose of a probiotic-containing yogurt product or an un-supplemented acidified milk placebo drink. The probiotic product also contained inulin as a “synbiotic.” During the four months of the trial, a variety of health and wellness measures were assessed.

The children receiving the supplement had fewer days of fever and better school and social functioning, as assessed by a validated instrument. The supplemented children had a tendency toward looser stools, possibly a function of the inulin included in the product.

Although the magnitude of these effects was quite modest, (if confirmed in a larger trial) they could be important because of the sheer numbers of children in day care. Thus, even though this study should not become the basis for a recommendation, it can certainly inform further investigations of the topic.

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## Transitional neonatal hypoglycemia

— Alan H. Jobe, MD, PhD

The blood sugar levels of all newborn infants fall after birth from fetal levels and can stay low for several days. The critical level for an intervention to increase the blood sugar remains most contentious, as does the selection of infants for screening and the frequency of screening. Further, quite low blood sugars are relatively common and symptomatic hypoglycemia is uncommon. In this issue of *The Journal*, a committee of the Pediatric Endocrine Society reports a scholarly analysis of mechanisms causing this normal transitional neonatal hypoglycemia in infants. The low blood sugars are not associated with ketosis, and there is a low glucose threshold for suppression of insulin secondary to an immature pattern of pancreatic beta cell function. The resulting low blood sugar values can confound the identification of infants with persistent and genetic causes of low blood sugars over the first days after birth. Further, the newer technology of measuring continuous subcutaneous glucose with implanted electrodes demonstrates rapid changes in glucose in high-risk preterm or growth-restricted infants in asymptomatic infants for weeks. It seems that the more we know, the less secure the clinician is about how to approach the detection and treatment of hypoglycemia in asymptomatic newborns. This analysis by Stanley et al is a valuable contribution toward further understanding the problem.

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