Highlights from this issue

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REAL LIFE: JUST FANTASY?

Lest anyone risks seducing themselves to the contrary, we should remind ourselves constantly how little (if anything) we genuinely know. Time gives us more familiarity with exposure outcome phenotype pattern recognition but do we get closer to really understanding? My question is clearly a rhetorical one and several papers illustrate this beautifully.[1]

BROTH AND ITS PROPERTIES

In the early 1990s, the treatment of severe malaria in areas of widespread resistance to *P. falciparum* was transformed by the 'emergence' of artemisin therapy. Really though, this was no more than the recognition of a property of the Quingao herb of which Chinese physicians had been aware for centuries: Like many other traditional remedies, it was administered in a hot broth. Artemisin combination therapy (ACT) is the cornerstone of WHO algorithms but, with evolving resistance, alternatives will be needed before long but, there is no reason to think that artemisin is alone among these home defervescent remedies. The delightful study by Stephen Marks and the children from Eden primary school in north London tested this hypothesis. Children (whose families came from Europe, the Middle East and US) were encouraged to bring samples of their own families' broth recipes for formal testing in vitro against asexual replication and transmission of *P. falciparum* against an artemesin control. The soups ranged from vegetarian, to beef to chicken based and none were thought to contain artemisin though 10% (at least one of which contained only red cabbage) showed gametocyte exflagellation inhibition. *See page 1138.*

FUNCTIONAL NEUROLOGICAL DISORDERS IN CHILDHOOD: WHAT HAPPENS NEXT

I think it's fair to say that many would have assumed that those children assessed for neurological disorders for which no medical explanation can be provided (the ICD 10 calls these 'dissociative', depersonalisation-derealisation' and 'neurasthenia') reappear with equally hard to pigeonhole problems as adults. But, no one really knows, or at least knew, until now now which is why Forsyth's cohort study is so welcome. Recruitment of children with functional neurological disorders (FNDs) presenting to child and adolescent mental health services began in the North East of England in the late 1990s. Each child old enough to have potentially had contact with adult services (n=114) was linked through adult mental health databases and proportion and risk factors for persisting calculated. The key findings were of an overall incidence of 6 out of 100 000 and a peak at the age of 16 years. Only 23% (much lower than might be expected) had adult service contact and there were no independent symptom predictors of recurrence in the regression model. Assuming case ascertainment was complete (in other words that patients didn't with time become disillusioned with follow-up and drop out), the data suggest a better outlook for child than adult onset FNDs. Heyman's editorial looks at the broad picture in terms of classification, the subsets within FNDs ('lumpers' and 'splitters') and, ultimate implications for multispoke management. *See pages 1161 and 1127.*

HEART TRANSPLANTATION

Despite unique complexities in terms of donor supply, immunological factors and unpredictability, rates of cardiac transplantation in children continue to increase both worldwide and in the UK, total figures currently of 14 000 and 1000 respectively. Reinhardt's update on what is now possible makes for compelling reading for anyone not directly involved with these children whose underlying pathology ranges from the failing Fontan to pulmonary hypertension secondary left to ventricular failure to poor quality of life to refractory arrhythmias. Children with congenital heart disease fare less well than those with acquired problems but advances in breadth of selection though HLA mismatching precludes transplantation, ABO incompatible recipients do as well as their matched counterparts. Bridging support in the form of Mechanical Circulatory Support (for example ECMO and ventricular assist devices) and the new option of donation after circulatory death have opened new doors untenable even a few years ago. *See page 1216.*

SHOCK PHENOTYPING

In 2011, the FEAST study in sub saharan Africa reminded us of our deficits. Fluid bolus treatment in shock, for so long the cornerstone of therapy was shown to cause harm to a population of children with a high malaria parasitaemia and anaemia prevalence. Though normal saline (and the attendant hyperchloraemic acidosis) came under scrutiny in the secondary analyses, but it is still unclear why more children in the bolus groups had a higher mortality. What is becoming apparent though is that shock is probably more than one entity or even two, the classic low output peripheral vasoconstrictive 'cold' shock in children and high output vasodilatory 'warm' shock in adults alone insufficient to explain differences in response phenotypes. Dewez' letter on the rate of changes in guidance is tempered by Weiss' editorial putting the response in perspective. We really know very little and, as most of the algorithms alluded to concern children in high income settings in which we have, so far no evidence of harm, the reality might be that context specific (and in the future perhaps even child genotype specific) guidance is the right approach. *See pages 1236 and 1125.*

VOICES FROM HISTORY

The delightful paper by Barraclough and Puntis chronicles the timeline of pivotal nutritional papers in *Archives* from Barlow's observations (issue 1, 1926) on rickets, to the children with marasmus and kwashiorkor encountered by Cicely Williams in Ghana in the 1950s, the history of 'stercometry' (and I'm not giving away any clues here…. read it!) to Widdowson and Chances elaboration of the science of food quality analysis to the evolution of specific enteral feeding in then 1980s. Perhaps surprisingly, broth isn't mentioned, but we've now learnt, it has powers beyond purely nutritional ones. *See page 1234.*

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