Table 1 Demographic characteristics, presenting clinical feature, and treatment of the patients

	Patient							
	1	2	3	4	5	6	7	8
Age at presentation	22 m	8 y	8 y	5 ½ y	10 y	5 y	8 y	10 y
Sex	F	F	F	M	F	F	M	F
Race	White	White	White	White	White	White	Vietnamese	White
Prodrome	−	Sore throat	−	−	Diarrhoea	Pustules	−	Tonsillitis
Presenting features								
Miserable	+	−	−	−	−	−	−	−
Rash	+	+	+	+	+	+	+	+
Joint pain	−	+	+	−	+	+	−	+
Joint swelling	+	−	+	−	+	+	−	−
Abdominal pain	−	−	+	+	−	+	+	−
Vomiting	−	−	−	+	−	+	+	−
Swollen testicle	−	−	−	+	−	−	−	−
Haematuria	−	+	+	−	+	−	+	+
Proteinuria	−	+	+	−	−	+	+	−
Rectal bleeding	−	+	−	−	+	−	−	+
Length of presentation	1 d	2 d	2 d	1 d	5 d	4 d	5 d	1 d
Presentation to treatment	10 d	14 m	4 m	18 m	5 d	8 d	11 d	1 m
Dose	1 mg/kg od	1.3 mg/kg od	1 mg/kg od	1.25 mg/kg od	0.75 mg/kg bd	1 mg/kg od	1 mg/kg od	0.5 mg/kg bd
Length of first course	6 d	7 d	4 d	4 w	10 d	7 d	14 d	10 d
Positive response	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Relapse after first course	No	Yes	No	Yes	Yes	Yes	Yes	Yes
Total duration of treatment	6 d	7 d	4 d	2 ½ y	8 m	5 w	5 w	2 y

d, day; w, week; m, month; y, year; +, present; −, absent; od, once a day; bd, twice a day.

6 **Thuong-Nguyen V**, Kadunce K, Hendrix JD, *et al*. Inhibition of neutrophil adherence to antibody by dapsone: a possible therapeutic mechanism of dapsone in the treatment of IgA dermatoses. *J Invest Dermatol* 1993;**100**:349–55.

If community paediatricians did not exist, it would be necessary to invent them

Since 1991 there has been talk of abolishing community paediatrics as a specialty.[1] At that time, a group of related specialties was proposed: a specialty of child development and rehabilitation (neurodisability); child protection would be subsumed into general paediatrics and there would be child public health doctors. Since then there has been a view among some paediatricians that community paediatricians should become the general paediatricians of the future.[2 3] Dr Chambers' recent article proposes a narrow view of community paediatrics, concentrating on chronic illness and confining its role to diagnosis and medical management.[4] He rather misses the point.

The challenge of community paediatrics

Children do not come in neat packages, with diagnostic labels. They and their families need all their needs met. Hospital practice traditionally concentrates on the illness, not the patient, although this is becoming less with time and paediatricians have always been more holistic than adult counterparts. Hospital practice often deals with complex problems by having specialists for each problem. Our adult physician colleagues are beginning to realise that doesn't work and are reinventing the general physician.

It has been shown that community paediatric patients have significantly more complex problems than those presenting to general paediatricians.[5] Many of the conditions we diagnose and treat have no diagnostic tests. Community paediatricians need excellent clinical skills, must be able to manage complexity and uncertainty, and must have the ability to communicate across disciplines and across agencies, creating understanding in those who come from different backgrounds and with different agendas. It is not an easy job.

The National Service Framework

The NSF was constructed by multidisciplinary groups including parents. It is therefore no accident that child health, not illness, is emphasised. Hospital practice has rather less emphasis than crosscutting ''out of hospital'' issues. Communication, coordination, and early intervention are all key themes. Parents and our sister agencies value medical input that is holistic, available where it is needed (not just in the clinic), and attuned to the needs of the child and family in the community. They demand more of it than we can currently give. Nevertheless, child health outside hospital has moved up the agenda and it will be hard for local authorities to deliver Every Child Matters without focused child health support to education, social, and voluntary services, as well as child health per se. This new agenda requires exactly the skills community paediatricians have. If community paediatricians did not exist, it would be necessary to invent them to deliver the NSF. The challenge is how we tackle it.

Dr C M Ni Bhrolchain
Consultant Community Paediatrician, Wirral Hospital NHS Trust, UK; cliona_nib@lineone.net

Competing interests: Dr Ni Bhrolchain in a Specialty Training Advisor in Community Child Health. These views are her own.

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Melatonin: a panacea for desperate parents? (Hype or truth)

Sleep disorders are common in children with neurodevelopmental disorder and are a major source of stress for the whole family. In children with neurodevelopmental disabilities the prevalence may be as high as 80%.[1] The current literature is suggestive of circadian rhythm dysfunction, social difficulties, and abnormal melatonin levels in children with autism.[2]

Hypnotics and sedatives can produce side effects and tolerance,[3] so is melatonin the answer in children with sleep problems associated with severe developmental difficulties of social and communicating nature, which have not responded to behavioural and social measure? Previous studies and case reports have suggested that melatonin could be effective.

We retrospectively reviewed cases of nine autistic children with chronic sleep disorder, who were attending the Child Developmental Centre at Windmill Lodge. The age range of these children was 2–11 years. No additional non-pharmacological sleep intervention was instituted. They were started on 2.5–5 mg melatonin 45 minutes before their sleeping time. In four of these patients sleep latency was reduced. Our own experience of reduction in sleep latency is in accordance with literature.[4] Five parents reported improvement in total duration of sleep. In

three patients medication was stopped within a week because of no response. Four patients are still on melatonin for over a year without any side effects. We could not find the cause in non-responders.

To find out the real benefit of melatonin, the dose, short and long term side effects, and group of patients who will respond to melatonin, several authors have already identified the need for a double blind cross-over study.[4] Previous studies have reported response rates of up to 80%,[5 6] but it is seems likely that studies which group together children with ''neurodevelopmental disorders'' in a generic manner will not furnish the answer as to the true place of melatonin in the management of disturbed sleep patterns.

R Gupta
Ealing Hospital NHS Trust, London, UK

J Hutchins
Ealing PCT, London, UK

Correspondence to: Dr R Gupta, Department of Paediatrics, Ealing Hospital NHS Trust, Uxbridge Road, Southall, London UB1 3EU, UK; reeta_pradeep@yahoo.com

Competing interests: none declared

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An integrated care pathway for looked after children can facilitate multi-agency coordination

Looked after children are a vulnerable population at risk of unidentified and unmet health needs. Coordinated input from health, social care, and education services for these children is required by government but is not easily achieved.

The focus on looked after children has sharpened with the Quality Protects programme, a major initiative launched in 1998 to improve their life chances. In 2002, the Department of Health (DH) published guidance on how to develop a health service for looked after children.[1]

''Children in special circumstances'', including looked after children, are prominent in the National Service Framework (NSF) for Children Young People and Maternity Services. Implementation of the DH guidance is explicitly required by the NSF.

The Children Act 2004 sets out a new framework for children's services with Directors of Children's Service and Lead Members for children in each local authority.[2] The government is establishing Children's Trusts to drive the coordination and integration of planning, commissioning, and delivery of health, social care, and education services.

How are these agencies to work together more effectively? There are well recognised facilitators and barriers to coordinating multi-agency practice.[3] Poor communication between agencies and a lack of understanding of each other's roles and responsibilities has been a barrier and is a recurring feature in reports of child abuse and child deaths.

An integrated care pathway (ICP) is a health sector concept that ''determines locally agreed multidisciplinary practice based on guidelines and evidence, where available, for a specific patient user group. It forms all or part of the clinical record, documents the care given and facilitates the evaluation of outcomes for continuous quality improvement''.[4] The ICP concept is multifaceted and complex but consists of both a process (of development and continuing maintenance) and a set of operational products. It can usefully be extended as a tool to improve multi-agency working.

An ICP to promote the health of looked after children has been developed in Birmingham. The products include a process map, updated health assessment documentation, and a variance reporting strategy.[5]

At its best an ICP can be a mechanism to enhance collaborative working across agencies for specific populations such as looked after children.

D Simkiss
Division of Health in the Community, Warwick Medical School, Coventry CV4 7AL, UK; d.e.simkiss@warwick.ac.uk

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BOOK REVIEWS

Spotting the sick child (DVD)

Edited by Ffion Davies. University Hospital of Leicester and Royal College of Paediatrics & Child Health, 2004, £8.99 single copy, or £6.46 for orders of six or more. ISBN 1 904039 11 1

This innovative joint project between the Department of Health and the Royal Colleges of Accident and Emergency Medicine and Paediatrics and Child Health is an extremely useful educational resource. The DVD was commissioned due to the concern of the Department of Health in England about door-to-needle times for meningococcal disease in children. The aim was to set up a video teaching package for A&E doctors and paediatricians about recognition of serious illness in childhood. The original remit was extended to include GPs, paramedics, emergency care practitioners, and others assessing children. I noticed that all the consultants received a copy as part of the Children's National Service Framework package and it looked interesting. The cartoon representations on the cover artwork show a worried-looking doctor bemused by caricatures of spotty, crying, febrile, and flushed children. This simple and inviting imagery nicely reflects the subject matter.

The DVD uses an interface which will be familiar to most. Seven menus, covering the top presenting emergency symptoms in childhood, function as gateways to symptoms based tutorials. This simple menu system is useful to get to a particular section quickly. But there is no opportunity to interact with clinical material or cases, or for making management decisions.

The opening sequence contains many of the images we will see during the DVD set to a symphony of crying, coughing, and calming background banter from parents, nurses, and doctors. It might put off healthcare professionals who are not used to this sort of decorum in a paediatric A&E, but it is a cute way to introduce the content. Following this there is a head-to-head edited interview with a ''TV doc'' and an A&E consultant (you can skip the entire intro at the push of a button). The conversation makes interesting watching as the TV doc tries to justify why spotting a sick child is so important. The A&E consultant gives a far more grounded perspective to assessing children in the clinical setting. The TV doc suggests there is a culture of practicing defensive medicine, but the A&E consultant (much more the voice of reason) declares it is more to do with human nature that we try our best to spot the sick child and not miss something important. Surely *safe* medicine *is* defensible and that should be the focus.

There are many great video clips shown, often with explanatory narrative and some with a visual caption. Being involved in a similar project locally to capture video of acute presentations and clinical signs for teaching I can appreciate the time and effort put into obtaining useable footage as well as the goodwill of patients and their parents. Some of the clips within each section are repeated—the same breathless baby, croupy cough, or miserable infant. But that is reinforcement and a useful educational tool. The ''red flags'' are particularly helpful, although some are no more than a ''talking head'' explaining a worrying symptom or making a learning point without any video or visual aid to back up or reinforce the point. It is worth mentioning that along with excellent footage of symptoms, signs, and clinical evaluation is a lot of talk. The team of presenters use a formal and didactic delivery style, assiduously reading their script from an autocue. The tone is serious which is appropriate for the topic material, but paediatrics can be a fun and up-beat speciality. Most sick children do get better!

I liked the 3 minute toolkit showing how an examination can be completed with the child on the mother's knee. I always think is nice to ask younger children if I can examine them