# In this issue

20 APRIL

## EATING DISORDERS SEVERE IN THE VERY YOUNG

Australia's first national study of early-onset eating disorders has found an incidence rate of 1.4/100 000 children aged 5–13 years, although this is likely to be an underestimate. Madden et al (*page 410*) looked at incident cases in this age group over 3 years, from reports made to the Australian Paediatric Surveillance Unit by paediatricians and child psychiatrists. Of 101 children who met the study's criteria, one in four were boys, 79 children were hospitalised and, although only half met the weight criterion for anorexia nervosa, many had serious complications such as hypothermia (33 children), hypotension (20) and bradycardia (40). In a linked editorial (*page 403*), Hay voices concern that the high rates of life-threatening complications suggest under-referral or under-recognition of the problem, and thus delays in specialist care. Lacking too is an evidence base to guide treatment.

## EXPOSURE UP, TRANSMISSION DOWN FOR PERINATAL HIV

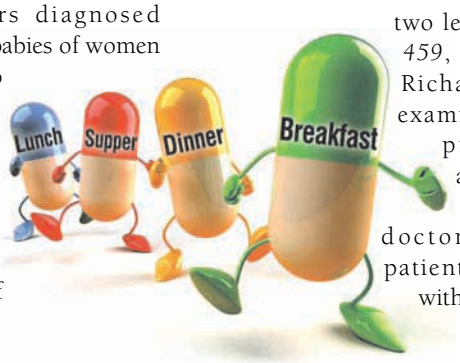
More babies are being born to HIV-infected mothers in Australia, but measures to reduce mother-to-child transmission appear to be effective if maternal HIV infection is diagnosed antenatally. So say McDonald et al (*page 416*) after describing the national patterns of perinatal HIV exposure and outcomes for babies born between 1982 and 2006. Despite increasing rates of exposure (2.3/100 000 in 1982–1996, rising to 8.3/100 000 in 2003–2006), the mother-to-child transmission rate declined significantly from 25% (4/16) in 1987–1990 to 5% (4/82) in 2003–2006 for mothers diagnosed antenatally. In 1999–2006, babies of women diagnosed antenatally who used at least two interventions to reduce transmission (antiretroviral treatment during pregnancy, caesarean birth and avoidance of breastfeeding) had a 1% chance of contracting the infection.

## A WORD FROM OUR SPONSOR?

Clinical guidelines appropriately form the basis of many management decisions but, on *page 446*, Millar poses some uncomfortable questions about a set of guidelines in current circulation. Written by an eminently qualified group, they nonetheless have not been endorsed by the NHMRC, published in a peer-reviewed journal or adopted by a recognised medical body — and their funding and dissemination appears to be linked to a company that manufactures the main drug they recommend. In reply, Fletcher says that the guidelines represent a summary of work reviewed and accepted by learned bodies elsewhere, and that industry support was acknowledged (*page 450*). Regardless of whether the guidelines are tainted, Van Der Weyden points to several aspects in which the process of their publication and dissemination was lacking, and the need for more guidance on, and transparency in, doctors' dealings with the pharmaceutical industry (*page 407*).

Many professionals do offer guidance in this area. On *page 406*, Shipp and Mallarkey from the NSW Therapeutic Advisory Group point to their recently updated position statement aimed at public hospital staff.

Meanwhile, recently published *MJA* articles touching on these issues have generated debate. In our *Letters*, Gandhi (*page 461*) warns that relying on drug company sponsorship for cancer trials may not lead to the best outcome measures being used, and two letters (Cole, *page 459*, and Dalton and Richards, *page 460*) examine some of the practical issues associated with the need for doctors to inform patients of their links with industry.




## SAY AHH ...

Throat complaints are not always straightforward, as illustrated by two case reports in this issue. Anguille and colleagues' patient required morphine for an acutely painful throat that appeared clinically normal. A D-dimer test held the key to the diagnosis and a life-saving procedure (*page 454*). By contrast, the man who presented to Alicandri-Ciufelli and colleagues' department appeared to have a markedly enlarged right tonsil, but an MRI scan confirmed the real source of the swelling (*page 457*).

## PREVENTING AND MANAGING CARDIOGENIC SHOCK

Patients with acute myocardial infarction (AMI) who are managed at non-tertiary hospitals are likely to benefit from a range of interventions to prevent and treat cardiogenic shock (CS), say O'Connor and Fraser (*page 440*) after reviewing the relevant research. Regional hospitals without intensive care or interventional facilities are the first port of call for many Australians with AMI. The authors included 35 studies, finding strong evidence for early thrombolysis in patients of all ages (ideally prehospital thrombolysis to prevent CS), and level 2 evidence for transfer of patients with CS for early revascularisation. They also recommended that insertion of an intra-aortic balloon pump be considered in patients with CS who do not have contraindications.

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### ANOTHER TIME ... ANOTHER PLACE

Much industry and little conscience make a man rich.

*Proverb*