

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

December 2013 • Volume 163 • Number 6

Copyright © 2013 by Mosby Inc.

Authorship criteria

— Monica L. Helton, BA
— William F. Balistreri, MD

The *Journal's* leadership looks to organizations such as the Committee on Publication Ethics (COPE) and International Committee of Medical Journal Editors (ICMJE) for guidance when developing editorial policies and procedures. Until recently, the three conditions of authorship outlined in ICMJE's "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" (http://www.icmje.org/ethical_1author.html) have served as *The Journal's* guidelines for authorship. In August 2013, ICMJE updated these requirements, now called "Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals" (ie, "ICMJE Recommendations") (<http://www.icmje.org/icmje-recommendations.pdf>). The most notable change in ICMJE Recommendations is in regard to authorship criteria.

Beginning January 1, 2014, *The Journal* will adopt the updated ICMJE Recommendations for authorship. All individuals in the author list must meet **all four** of the updated ICMJE authorship criteria: "(1) substantial contributions to the concept or design of the work; or the acquisition, analysis, or interpretation; AND (2) drafting the work or revising it critically for important intellectual content of data for the work; AND (3) final approval of the version to be published; AND (4) agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved." If an individual contributed to the study and/or the manuscript but does not fulfill all four conditions of authorship, he/she should be included in the Acknowledgments section of the manuscript. Additional information about authorship can be found in *The Journal's* Guide for Authors (<http://www.jpeds.com/authorinfo>).

Because authorship is such an important and sensitive topic, researchers are strongly encouraged to discuss and decide who will be listed as an author (based on ICMJE Recommendations) when the study is being conceived and designed. The criteria should be revisited throughout the study and again prior to submission of the manuscript. If you have any questions about what constitutes authorship, please feel free to e-mail the Editorial Office (journal.pediatrics@cchmc.org), and we would be happy to provide clarification. In our experience, it is much easier to decide authorship based on ICMJE Recommendations prior to manuscript submission than to change it later in the process. The latter requires e-mailed confirmation from all authors, including those who were added or deleted from the author list, resulting in delays in processing the manuscript. If an author is added or deleted at any point after submitting the manuscript, please notify *The Journal* as soon as possible.

Pediatricians fall short on screening adolescents for HIV infection

— Sarah S. Long, MD

Currently a striking 40% of all new HIV infections are diagnosed in adolescents, who make up just 25% of the US population. A substantial number of adolescents do not know that they are infected, which is a risk for themselves and others. In recognition of the new epidemiology and change in incidence of HIV, the Centers for Disease Control and Prevention (CDC) recommended in 2006 that primary care providers (PCPs) offer "opt-out" HIV screening to all adolescents 13 years of age and older (as well as adults through 64 years of age) in all health care settings regardless of perceived individual risk. Six years later, Goyal et al performed an anonymous cross-sectional internet-based survey of pediatric PCPs in 5 academic primary care

centers and 22 community-based primary care offices, a network affiliated with the Children's Hospital of Philadelphia. The survey queried adherence, attitudes, and barriers related to CDC guidelines on HIV screening. The report details and analyzes 101 evaluable surveys (53% response rate).

Results show that pediatricians fall short on performance of this critical health screen and probable opportunity for prevention through raising patient knowledge and awareness. Only 40% of pediatric PCPs reported offering HIV screening "most" or "all of the time" during routine visits, although they addressed violence on 60% of visits and substance abuse and depression each on >90% of visits. Even more striking is that <10% of pediatric PCPs answered questions on CDC and state HIV screening recommendations correctly. Of 20 potential perceived barriers, PCPs identified a mean 4.8. Most frequently identified barriers were related to confidentiality, time needed for counseling, and follow-up.

Pediatricians are defined as "super docs" of anticipatory guidance and risk aversion for our patients — at least for infants and toddlers. We need to "mind" the health of our aging charges with the same zeal and acceptance of responsibility.

[Article page 1711 ►](#)

Treatments for retinopathy of prematurity

— Alan H. Jobe, MD, PhD

Retinopathy of prematurity (ROP) is a major complication of the care and survival of very preterm infants. Although prevention clearly is better than treatment, but prevention currently is not possible, even with careful regulation of blood oxygen saturation in very preterm infants. This disease of very preterm infants was initially treated with cryotherapy to destroy vascular hyperproliferation that progresses to blindness. Laser photocoagulation then replaced cryotherapy as a more targeted and less destructive therapy with considerable success. Recent research has identified vascular endothelial growth factor (VEGF) as a major mediator of neovascularization, and intraocular injection of antibodies against VEGF is a promising new therapy for ROP. This therapy avoids the focal retinal destruction caused by laser therapy.

In this issue of *The Journal*, Filippi et al report that systemic treatments of preterm infants with stage 2 ROP with propranolol decreased progression and the need for treatment with laser or intraocular anti-VEGF antibodies relative to a randomized control group. The logic for propranolol was based on animal studies and the beneficial effects of beta-blockers on neonatal hemangiomas. However, the benefits of propranolol for decreasing the progression of ROP were tempered by the cardiovascular effects of systemic beta-blockade in very preterm infants. These provocative results suggest that local ocular treatments with propranolol may be safer and of substantial benefit. We all await a cheap and easy treatment for ROP.

[Article page 1570 ►](#)

Estimating glomerular filtration rate

— Thomas R. Welch, MD

For decades, serum creatinine has been used as a widely available surrogate for glomerular filtration rate (GFR). Formal determinations of actual GFR are rarely obtained in clinical practice.

The problem is that creatinine is not perfect in this role. Although its imprecision is tolerated in most clinical settings, there are times when a more reliable estimate of GFR is needed. This is becoming a particular problem as we recognize the importance of early detection of modest reductions in GFR, in both acute and chronic situations.

The most widely known modification to stand-alone measurement of creatinine is the Schwartz equation, which uses creatinine and height to calculate an estimated GFR. Use of this method requires knowledge of patient height, which is not always available. In this issue of *The Journal*, Blufpand et al test two alternative GFR-estimating equations along with the Schwartz equation, in a group of 152 children for whom actual inulin GFRs were also available. One of these new equations (the "eGFR-Pottel") was comparable with the GFR estimate from the Schwartz equation.

eGFR-Pottel potentially may eclipse the Schwartz method, although it is probably too early to predict where this is going. At the very least, as indicated by the authors,

Relationship of hyponatremia in bronchiolitis to clinical outcomes

— Robert W. Wilmott, MD

this method may permit reporting of eGFR as part of routine laboratory reports, something that is currently done with adults but until now could not be done for children.

[Article page 1722 ►](#)

For many years, hyponatremia has been recognized in adult critical care as a predictor of worse outcomes. The reasons for the phenomenon are not clear but may be due to the direct effects of reduced sodium concentrations leading to abnormal fluid shifts. Some of these patients have syndrome of inappropriate anti-diuretic hormone, and others have iatrogenic fluid overload. There have been few studies in the pediatric population. In this issue of *The Journal*, Luu et al from the University of Colorado report a retrospective cohort study of children admitted to the pediatric intensive care unit (PICU) with bronchiolitis. Serum sodium concentrations were obtained within the first two hours of admission and correlated with clinical outcomes. Results showed that 22% of 102 children had hyponatremia within two hours of admission. These children had increased mortality, increased days on the mechanical ventilator, increased PICU length of stay, and increased need for noninvasive ventilatory support. The authors conclude that children with bronchiolitis who have a serum sodium of less than 135 mEq/L within two hours of admission to the PICU fare worse than their cohorts with normal sodium values. This conclusion begs the question: What is the mechanism, and should this be the focus of future investigations? The type and composition of fluid administered during the first 24 hours will be an important variable to study.

[Article page 1652 ►](#)

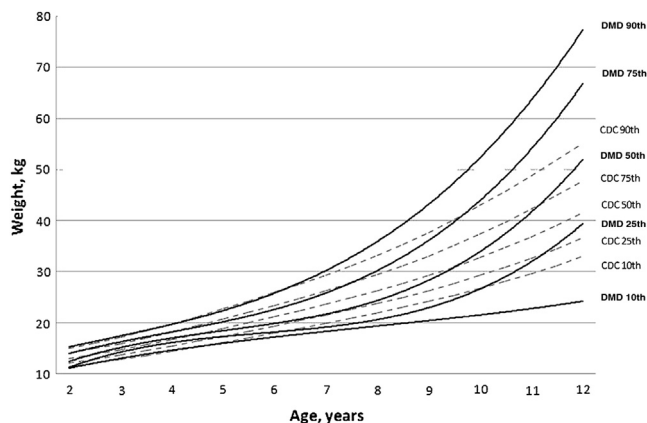
Growth in Duchenne muscular dystrophy

— Thomas R. Welch, MD

In the past few years, there has been a proliferation of growth charts specific for children with certain conditions, often genetic. These are helpful in separating growth abnormalities related to the underlying condition from others that may be treatable or show evidence of comorbid disturbances.

In this issue of *The Journal*, West et al provide specific growth charts for boys with Duchenne muscular dystrophy (DMD). Children with DMD are at risk for extremes in growth problems. Decreased metabolic expenditure may present a risk factor for obesity, and weight loss from malnutrition may characterize the latter stages of the disease. The use of corticosteroids may further confabulate the analysis of growth.

These growth curves, derived from nearly 2000 individual measurements, should be of great value to clinicians caring for children with DMD.



[Article page 1759 ►](#)