

Preventing accidental injuries in children: champions needed in primary care

'The child is burned! I never hear that announcement without a shudder, for it has opened the portals to a long avenue of pain and distress, an avenue that may lead to an age-long disfigurement and too often, by shorter ways, to the tragedy of death. Let us take counsel together about it. Wherein are its dangers? What are its risks? How can disaster be mitigated or avoided?' (Sir John Fraser)¹

During my vocational training in general practice I spent 6 months as a senior house officer in the accident and emergency department of Alder Hey Children's Hospital in Liverpool. I still recall the quiet Saturday when we received a telephone alert from the ambulance control centre to say that two children that had been involved in a serious house fire were on their way. I assisted the consultant surgeon as he administered intravenous morphine to ease the pain in the resuscitation area, and the memory of that day has remained with me. Years later, I came across the quotation above when preparing the literature review for my MD thesis on the prevention of accidents to preschool children, and it eloquently sums up why I remained interested in the topic. It is unusual to start an editorial in such a personal way but I make no apologies for doing so. It has long been known that children living in deprived areas have higher hospital admission rates and that there is a steep social-class gradient for accidents such as house fires and road traffic accidents.²

Injury is still the leading cause of death in children in all industrialised countries. Statistics from the Office of National Statistics show that there were 340 deaths from injuries and poisoning in England and Wales for children aged 0–14 years in

2002.³ It is also the major cause of ill health and disability. Although the number of deaths from unintentional injuries is falling, the number of children injured each year remains unacceptably high. In a 2001 survey of 96 Dutch general practices, Otters *et al* found that unintentional injury accounted for 9% of all new health problems in children aged up to 17 years.⁴ If appropriate strategies are to be developed and implemented, a better understanding is needed of the factors that place some children at an increased risk of unintentional injury compared to their peers — and general-practice based studies provide an excellent base to locate such research.⁵

The prevention of accidental injuries to children has been identified as a priority for action in this country for more than a decade.⁶ *Saving Lives, Our Healthier Nation*⁷ set national targets to reduce death rates from accidents by at least 20% and the rate of serious injury by at least 10% by 2010; and announced that an Accidental Injury Task Force would be set up to advise on how to achieve these targets. Its terms of reference were to advise the Chief Medical Officer on:

- the most important priorities for action in order to meet the target;
- the development of an implementation plan, consulting with other stakeholders as necessary;
- whether the necessary delivery structures are in place to take forward the implementation plan;
- how progress on the implementation plan should be monitored; and
- how to develop and publicise a more united approach to accident prevention across Government and the NHS.

The Task Force completed its report, but it is disappointing that awareness of

its content has been low and the subject never quite grabbed the attention it undoubtedly should.⁸ One difficulty is that for preventative action to be effective, it must be coordinated across a range of agencies, and, within Government, given priority by several departments. In a sceptical way one might include it with other areas of public health where the contributions that individual doctors and health visitors can make with individual families is perceived as limited, and has to be part of a much more difficult, wide-ranging population or community initiative. It might also be part of the way that we accept some aspects of public health through a form of complacency (the most obvious example being the constant toll of death from road traffic accidents). Research into childhood accidents has also continued to be a low priority at a national and international level, and it is a positive step to see two papers in this edition of the Journal addressing the topic.^{4,9}

Primary healthcare teams can have an important contribution to make to the prevention of accidental injuries in children including home safety counselling, participation in safety-equipment loan schemes, and the provision and fitting of free safety equipment.^{10–12} Kendrick *et al* highlight that the recent National Service Framework for Children specifies that primary care trusts (PCTs) and local authorities should develop injury prevention strategies and have child health promotion programmes addressing injury prevention.¹³ It will be interesting to see how much emphasis is given to the topic by already stretched PCTs. Kendrick had already pointed out that accidental injury was a neglected area within the earlier primary care groups and trusts.¹⁴

Systematic reviews have found that home safety counselling or education,

with or without the provision of safety equipment, can increase the use of safety equipment and improve safety behaviours in the short term, but the effect on unintentional injury is less clear.¹⁵ Many of the trials included in these reviews were conducted in the US, limiting the generalisability of their findings to the UK. In addition, reviews have highlighted the lack of high quality randomised controlled trials with adequate power and sufficient follow up periods.¹⁶

Kendrick *et al* have focused their attention on reducing the use of baby walkers for this cluster randomised trial in primary care. The injury risk associated with the use of baby walkers is not new, and has been identified as an international problem that crosses cultural divides.^{17–19} This paper is the first published trial to assess the effectiveness of providing education regarding baby walkers in a primary care setting. The authors conclude that an educational package delivered by midwives and health visitors can be effective in reducing baby walker possession and use. PCTs should take note of this study and include baby walker education in their injury prevention strategy.

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NICE suspected cancer guidelines

The National Institute for Health and Clinical Excellence (NICE) *Referral Guidelines for Suspected Cancer*¹ are the update of those issued by the Department of Health guidelines of 2000,² which were usually referred to as the '2-week wait' guidelines.

These guidelines are different in nature to the large majority of guidelines that NICE produces as they are not for a specific condition, for example schizophrenia or epilepsy. These guidelines are about the referral of patients with suspected cancer. Since early diagnosis is a priority, the large majority of patients will not actually have

cancer. The diagnosis of advanced cancer is easy, and the guidelines relating to this can appear patronising, but the challenge is to detect cancers early. The positive predictive value of rectal bleeding for colorectal cancer is less than 1 in 1000 in the community, 1 in 50 in general practice and 1 in 3 of those referred to hospital by GPs.³ The guidelines cover 12 different cancer groups, and these are very different diseases. In the case of symptomatic breast cancer, over 90% of women have a breast lump at presentation and survival is 77% at 5 years, while with lung cancer, only 5% present with a 'typical' symptom of

haemoptysis, and only 6% survive 5 years.

The new guidelines have been produced within a timescale that has allowed a rigorous examination of the evidence. They have been produced by a multidisciplinary team with patient representation. GPs and primary care clinicians have outnumbered the specialists. The guidelines are divided into 11 major cancer groups with a further section on children's cancers. Each section contains differences from the Department of Health guideline, for example the melanoma advice now includes a 7-point weighted checklist. The