Highlights from this issue

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One of the great joys of working with children is that very few—in fact I'd guess nearly none—of my patients have read the same textbooks and journals as me. This means that they don't feel particularly bound to present or have their conditions behave in the way that I, as an erudite and learned person of many years of experience, might expect. Children laugh at me, and on more levels than one. They look with contempt on my years of learning and experience, and, with a mischievous look, they prick my pomposity by doing things their own way. As a career, working with children is exhausting and refreshing at the same time; we don't get to become bored. We do, however, develop coping strategies. One of the important realisations is that children don't present with diseases—they present with symptoms, and sometimes signs. This is a bit odd because most of our textbooks, and many of our journal articles are based on diseases. It struck me a little while ago that one of the reasons the Fifteen Minute Consultation section is popular is that it often focuses on symptoms and signs, and strategies to sift these into a classification, sometimes by diagnosis, sometimes by 'what to do next'.

This month we've a few interesting papers which approach children from the perspective of their symptoms. Ben McNaughten, Thomas Bourke and Andrew Thompson suggested to me that they write about pica (***see page 226***). I thought to myself: 'Well, I know all about that'. Then I remembered that I didn't really know that much about it and that when a child with pica was referred I tended to ask around and refresh my knowledge—or anxieties—about what were the basics I should be doing. Then it occurred to me that I'd not actually seen a paper which simply approached the child from the perspective of this symptom before, or if I had it was long forgotten. It was great to eventually get the finished article, which I hope you enjoy and makes your outpatient clinics run a little more smoothly. It's this month's editor's choice.

This focus on how children actually present also helps explain the popularity of some of our other sections. I've written before about how much I enjoy the Epilogue section—the name invented when I had a bit of an obsession that every section in the journal should have the letters E and P in it. People ask me often why it is that they can't get their case report published. There are two answers to this. First, they (probably) can—just submit to *BMJ Case Reports*. Second, if you genuinely think about what it was that interested you about your clinical experience which led you to write your case report, although you'll say at first that it was the eventual diagnosis, I'd be prepared to bet that what really interested you during your clinical experience was the journey. Epilogues aim to reproduce those journeys—as do the longer, more detailed Problem Solving in Clinical Practice papers. The solved puzzle—crossword, murder mystery, clinical experience resulting in an end diagnosis we can then address—these all provide us with satisfaction. But it is only really the satisfaction of having made the journey—I'd not enjoy a book of completed crosswords or a murder mystery where the murderer was revealed on the front cover. And I don't much like case reports.

Which brings me to my final point. If you wanted to get involved in writing and if you wanted one of us to come and talk with your group—at a training or study day, or other teaching event—then please do get in touch and we'll see what we can do. As ever, if you've suggestions, then please do get in touch.

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