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One of the challenges in delivering an journal like *Ed&P* is getting the balance right between articles on conditions, tests or skills that you, the readers, will need on a daily basis, and those which you might need only once in a while but have other appeal. This other appeal may have a number of aspects. They may simply be interesting, or contain important information, or they may stimulate other serendipitous thoughts.

This issue has a range of articles which I hope will do all of these for you. This month's editor's choice is a thought provoking paper about the measurement of urine catecholamines by Daniel Erdelyi, Martin Elliott and Bob Phillips (***see page 107***). You'll probably suspect a little bit of 'Old Boys Club' with this choice – me focusing on another paper co-written by a fellow editor, but let me try to explain what this paper does for me. First, it gives me a good, but brief, review of neuroblastoma – which I can always do with. Second, it gives me something to take back to my local lab – in short, we should be doing spot urinary catecholamines, since they are as helpful as a 24-h collection, and an order of magnitude more convenient to collect. It seems that it is only inertia – and perhaps distance from the practical challenge of having to collect that much urine – that stops us from moving to spot urine collection. Third, I should stop worrying about phaeochromocytoma. Which, of course, is an overstatement, but I take it as particularly telling that during the earlier drafts of this paper the tertiary oncologist authors responded to questions about phaeo along the lines of 'Oh; it hadn't occurred to us that you'd seriously consider that as a differential – it's so rare, and the clinical features are so clear'.

Where's the serendipity then? That's in table 2 of the paper, and I'd strongly suggest taking a few minutes to digest what it's saying. What the authors have done is apply this test to a series of populations or clinical scenarios with different prevalence of the condition, and done some simple arithmetic to look at what a positive or negative test actually means in terms of subsequent likelihood that the patient has neuroblastoma. This isn't a lesson that can be repeated too often. I run a short teaching session based on (meaning ripped off from) an article from Bad Science, Crystal Balls and Positive Predictive Values, which you can find here: http://bit.ly/CrystalBalls. I did the pencil and paper version of this myself probably five times and was astounded at the outcome each time, and find that people I take through the exercise are equally shocked; that good tests, badly used can give frighteningly bad results. Take a look back at the top line of table 2 and think about what this means in terms of what you say to the patient's family: 'Um, I think your child has a possibly pretty unpleasant diagnosis. But I'm only two-thirds sure that my test result, which is reading positive, actually is positive'.

We have some quite eclectic other papers for you this month. There's a discussion about how we should be assessing analgesia in trials in neonates (***see page 112***). There's a review of the long-term care of patients after liver transplantation (***see page 82***). There's a paper on how to treat malaria in the UK – which, for our international readers, should probably be read along the lines of 'in the developed world' (***see page 87***). On this subject, I've worked with generations of registrars who have found our approach to treatment of malaria genuinely perplexing, given what they've learnt in their country of origin; this short article helps frame treatment in a UK context. Starkey and Sammons review the pharmacology behind sedation (***see page 101***) in a great article to read alongside the recent publication of National Institute for Health and Clinical Excellence guidelines on sedation in children which can be found here: http://www.nice.org.uk/CG112. And I can usually find something in the issue which I've never even heard of before; this month it is specific immunotherapy to prevent progression of allergic rhinitis (***see page 91***).

Finally we've an interesting Picket paper this month about an important area – which has, in the past been relatively unpopular to study (***see page 119***). None of the three antiepileptic medicines used to treat absence seizures is high cost, and therefore some of the drivers to conduct a randomised controlled trial have been missing. This is the sort of thing that the Medicines for Children Research Network in England is intended to address – although this is not their study. The outcome? Well, read the Picket, and perhaps the original paper too. It's changing my practice.

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