

Lus pour vous! Für Sie gelesen!

«Vision et participation» – Idées pour une école favorable à la santé

«Vision et participation», tels étaient à la fois le titre et le programme de cette manifestation: l'ensemble des participants ont en effet été invités à mettre en images une école favorable à la santé. Les actes du colloque qui a réuni à Fribourg les 4 et 5 septembre dernier 280 spécialistes actifs dans les domaines de la promotion de la santé et de l'instruction publique, sont maintenant disponibles sous la forme d'un rapport de 150 pages. Il s'agit de l'une des bases sur lesquelles se fondera la conception de la phase 2003 à 2010 du programme «Ecoles et santé», une entreprise conjointe de l'Office fédéral de la santé publique (OFSP), de la conférence suisse des directeurs cantonaux de l'instruction publique (CDIP) et de la Fondation 19.

Le programme «Ecole et santé» vise à faire de l'école un lieu d'apprentissage de modes de vie favorables à la santé. Les premiers projets ont démarré en 1997 et, parmi plus d'une centaine de projets déposés, 33 ont été sélectionnés et bénéficient d'un soutien financier. Ils sont présentés dans la brochure «Ecoles et santé – les projets en cours 2000/01». rs

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[http://www.bag.admin.ch/sucht/
publikationen/f/schulprojekte.htm](http://www.bag.admin.ch/sucht/publikationen/f/schulprojekte.htm)

Randomised controlled trial of three day versus 10 day intravenous antibiotics in acute pyelonephritis: effect on renal scarring

*Benador D, Neuhaus TJ, Papazyan JP, Wil-
li UV, Engel-Bicik I, Nadal D, Slosman D,
Mermillod B, Girardin E.
Arch Dis Child 2001; 84 (3): 241–6*

Background: Acute pyelonephritis often lea-
ves children with permanent renal scarring.

Aims: To compare the prevalence of scar-
ring following initial treatment with antibio-
tics administered intravenously for 10 or
three days.

Methods: In a prospective two centre trial,
220 patients aged 3 months to 16 years
with positive urine culture and acute renal
lesions on initial DMSA scintigraphy, were
randomly assigned to receive intravenous
ceftriaxone (50 mg/kg once daily) for 10
or three days, followed by oral cefixime
(4 mg/kg twice daily) to complete a 15 day
course. After three months, scintigraphy
was repeated in order to diagnose renal
scars.

Results: Renal scarring developed in 33%
of the 110 children in the 10 day intrave-
nous group and 36% of the 110 children
in the three day group. Children older than
1 year had more renal scarring than in-
fants (42% [54/129] and 24% [22/91],
respectively). After adjustment for age,
sex, duration of fever before treatment,
degree of inflammation, presence of vesi-
coureteric reflux, and the patients' recruit-
ment centres, there was no significant dif-
ference between the two treatments on
renal scarring. During follow up, 15 child-

ren had recurrence of urinary infection with
no significant difference between the two
treatment groups.

Conclusion: In children with acute pyelo-
nephritis, initial intravenous treatment for
10 days, compared with three days, does
not significantly reduce the development
of renal scarring.

Commentaire

Etude Suisse, citée dans les recommen-
dations du groupe suisse de travail de né-
phrologie pédiatrique sur le traitement des
infections urinaires de l'enfant (Paediatrica,
2001, Vol. 12, No. 1, p. 10–13 – [http://
www.ssp.hin.ch/paediatrica/vol12/n1/
pyelo-fr.htm](http://www.ssp.hin.ch/paediatrica/vol12/n1/pyelo-fr.htm)), montrant l'efficacité compa-
rable d'un traitement antibiotique paren-
téral court (3 jours) à celui d'un traitement
parentéral prolongé (10 jours). Ce travail
montre également l'importance, malgré le
traitement, des cicatrices rénales séquel-
laires (plus d'1/3 des cas) et leur préva-
lence plus marquée chez l'enfant plus âgé
que chez le nourrisson. rt

Clinical practice guideline: treatment of the school-aged child with attention-deficit/ hyperactivity disorder

*American Academy of Pediatrics. Subcom-
mittee on Attention-Deficit/Hyperactivity Dis-
order and Committee on Quality Improve-
ment.*

Pediatrics 2001; 108: 1033–44

This clinical practice guideline provides evi-
dence-based recommendations for the treat-

ment of children diagnosed with attention-deficit/hyperactivity disorder (ADHD). This guideline, the second in a set of policies on this condition, is intended for use by clinicians working in primary care settings. The initiation of treatment requires the accurate establishment of a diagnosis of ADHD; the American Academy of Pediatrics (AAP) clinical practice guideline on diagnosis of children with ADHD¹ provides direction in appropriately diagnosing this disorder. The AAP Committee on Quality Improvement selected a subcommittee composed of primary care and developmental-behavioral pediatricians and other experts in the fields of neurology, psychology, child psychiatry, education, family practice, and epidemiology. The subcommittee partnered with the Agency for Healthcare Research and Quality and the Evidence-based Practice Center at McMaster University, Ontario, Canada, to develop the evidence base of literature on this topic.² The resulting systematic review, along with other major studies in this area, was used to formulate recommendations for treatment of children with ADHD. The subcommittee also reviewed the multimodal treatment study of children with ADHD³ and the Canadian Coordinating Office for Health Technology Assessment report (CCOHTA).⁴ Subcom-

mittee decisions were made by consensus where definitive evidence was not available. The subcommittee report underwent extensive review by sections and committees of the AAP as well as by numerous external organizations before approval from the AAP Board of Directors. The guideline contains the following recommendations for the treatment of a child diagnosed with ADHD: Primary care clinicians should establish a treatment program that recognizes ADHD as a chronic condition.

Commentaire

Ces recommandations concernent le traitement des enfants entre 6 et 12 ans atteints de syndrome de déficit d'attention avec ou sans hyperactivité (ADHD). Elles visent à aider le praticien dans son choix parmi les options thérapeutiques. A confronter avec l'article de M. Hämmerli et S. Mühlebach «Risque cardio-vasculaire lors d'utilisation de méthylphénidate?» dans ce même numéro de Paediatrica. rt

¹ The treating clinician, parents, and child, in collaboration with school personnel, should specify appropriate target outcomes to guide management.

² The clinician should recommend stimulant medication and/or behavior therapy as appropriate to improve target outcomes in children with ADHD.

³ When the selected management for a child with ADHD has not met target outcomes, clinicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of co-existing conditions.

⁴ The clinician should periodically provide a systematic follow-up for the child with ADHD. Monitoring should be directed to target outcomes and adverse effects, with information gathered from parents, teachers, and the child.