Honey for Nocturnal Cough (*Arch Pediatr Adolesc Med 2007; 161: 1140-1146*)

This partial double blind trial compared the effects of a single nocturnal dose of honey or honey-flavored dextromethorphan with no treatment on nocturnal cough and sleep difficulty associated with upper respiratory tract infections. One hundred five children aged 2 to 18 years with upper respiratory tract infections, nocturnal symptoms, and illness duration of 7 days or less were recruited. Significant differences in symptom improvement were reported between treatment groups, with honey consistently scoring the best and no treatment scoring the worst.

COMMENTS In a comparison of honey, dextromethorphan, and no treatment, parents rated honey most favorably for symptomatic relief of their child's nocturnal cough and sleep difficulty due to upper respiratory tract infection.

Rapid Antibody Testing for Celiac Disease (*BMJ 2007; 335: 1244-1247*)

This study evaluated the feasibility and diagnostic accuracy of screening for celiac disease by rapid detection of IgA antibodies to tissue transglutaminase in a primary health care setting. District nurses screened 2690 children; 6 years old by sending finger prick samples for laboratory determination of IgA and IgG antibodies to endomysium and IgA antibodies to tissue transglutaminase. Children with positive rapid test results were subjected to biopsy of the small intestine. Thirty seven children (1.4%, 95% CI 0.9% to 1.8%) had biopsy confirmed celiac disease. Only five of these children had been diagnosed clinically before screening. The sensitivity of rapid testing was 78.1% (70.0% to 89.3%) and specificity was 100% (88.4% to 100%). Trained laboratory workers detected 30/31 newly diagnosed IgA competent patients with the rapid test kit used blindly.

COMMENTS Children with celiac disease detected at screening were smaller and had poor health status than their peers but they improved on a gluten-free diet. A simple rapid antibody test can enable primary care nurses to detect patients with celiac disease in the community.

Complementary Feeding: Position Paper (*J Pediatr Gastroenterol Nut 2008; 46: 99-110*)

This position paper on complementary feeding summarizes evidence for health effects of complementary foods. It focuses on healthy infants in Europe. After reviewing current knowledge and practices, they have formulated these conclusions: Exclusive or full breast-feeding for about 6 months is a desirable goal. Complementary feeding (i.e., solid foods and liquids other than breast milk or infant formula and follow-on formula) should not be introduced before 17 weeks and not later than 26 weeks. There is no convincing scientific evidence that avoidance or delayed introduction of potentially allergenic foods, such as fish and eggs, reduces allergies. During the complementary feeding period, >90% of the iron requirements of a breast-fed infant must be met by complementary foods, which should provide sufficient bioavailable iron. Cow's milk is a poor source of iron and should not be used as the main drink before 12 months, although small volumes may be added to complementary foods.

COMMENTS It is prudent to avoid both early (<4 months) and late (≥7 months) introduction of gluten, and to introduce gluten gradually while the infant is still breast-fed, inasmuch as this may reduce the risk of celiac disease, type 1 diabetes mellitus, and wheat allergy. Infants and young children receiving a vegetarian diet should receive a sufficient amount (approximately 500 mL) of breast milk or formula and dairy products. Infants and young children should not be fed a vegan diet.

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