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Essential tremor

The Clinical Update on essential tremor by Julián Benito-León and Elan Louis (April 7, p 1152)[1] admirably describes the diagnostic criteria, but fails to address the issues that affect patients after a correct diagnosis has been made. A clear explanation of the nature of the disorder is required to mitigate lingering doubts that the patient might have about Parkinson's or Wilson's disease. This point is especially important if the diagnosis has been delayed after failure to respond to increasing doses of anti-Parkinsonian medication.

Patients should be made aware of the possible alleviation of tremor by alcohol, and the accompanying dangers. In my series,[2] fewer than a third of patients gave a clear history of a familial tremor but many others had been brought up to avoid alcohol, thus raising the suspicion that other family members overindulged.

Treatment can be intermittent. The drugs, including alcohol, can cause temporary cognitive and physical impairment; thus a patient might be advised to experiment to find the minimum dose that will suppress the tremor before a job interview or a public performance. Acquired mannerisms might be recognised as useful "gestes", partly suppressing tremor.

Essential tremor can vary from an annoyance to severe or disabling. Benito-León and Louis rightly stress that more drastic measures, including surgical intervention, are occasionally required.

I declare that I have no conflict of interest.

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Early manifestations of polycystic kidney disease

Vicente Torres and colleagues (April 14, p 1287)[1] provide an excellent Seminar on autosomal-dominant polycystic kidney disease (ADPKD). We would like to add some aspects on early-manifesting ADPKD—an important issue for the management of affected families and which will give valuable insights into the pathogenesis not only of PKD but also the general concept of modification of disease expression.

Conflicting data exist on the concise proportion of ADPKD patients who present with an early-manifesting clinical course (eg, clinical symptoms before age 15 years); however, a rough estimate is about 1–2%.[2] Given the prevalence of ADPKD (1/400 to 1/1000), early-onset ADPKD is clearly an important and frequent diagnosis for paediatric nephrologists. Some children have substantial perinatal or neonatal morbidity and mortality and can be indistinguishable from those with severe autosomal-recessive disease (ARPKD). In a systematic study on the clinical picture and genetics of 207 children with PKD, 115 had autosomal-recessive and 92 autosomal-dominant disease, 9% of whom were diagnosed prenatally (ARPKD 10%), clearly emphasising the effect of early-onset ADPKD even among these most severe cases (unpublished data).

For affected individuals and their families, the distinction between ARPKD and ADPKD makes a wide difference and is crucial for clinical management and genetic counselling. Thus, we share Ogborn's view that PKD is a truly paediatric problem, and that the single most useful investigation in the assessment of a child with early-onset cystic renal disease of unknown underlying disease entity is ultrasonography of the parents.[3]

We declare that we have no conflict of interest.

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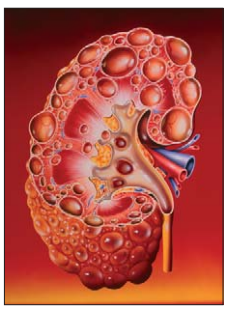
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Reducing harm caused by substance use in adolescents

J W Toumbourou and colleagues (April 21, p 1391)[1] provide an excellent summary of the current knowledge on interventions to reduce harm associated with adolescent substance use. We are sorry that they did not include recent evidence on treatment outcome for homeless young people with substance use problems.

According to UNICEF, street children are people younger than 18 years who spend most of their time on the streets. There are an estimated

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Figure: **Street children in Tegucigalpa, Honduras**

10–100 million street children and young people worldwide, mostly in developing countries.[2]

Substance abuse and mental and physical health problems among street children are substantial problems and the provision of medical care poses enormous challenges to organisations working with this population. Baer and colleagues[3] found that 69% of their homeless sample met criteria for dependence for at least one substance.

Since March, 2005, in the Médecins Sans Frontières day centre in Tegucigalpa, Honduras, 632 street children and young people have attended medical and mental health consultations (figure). Most consultations relate to reproductive health problems, substance use, depression, and physical trauma.

Regarding substance use, we have adapted the treatment approaches of Slesnick and colleagues, who showed that young people who received a standard treatment protocol targeting substance abuse behaviour reported significantly reduced substance use and depression, and improved social stability.[4,5] These studies were the first to show that homeless young people can be engaged into treatment and respond favourably to intervention efforts.

We hope that researchers will prioritise the development of treatment strategies for homeless young people facing substance use problems and that future reviews will not forget this group of extremely vulnerable individuals.

We declare that we have no conflict of interest.

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J W Toumbourou and coauthors' series paper on interventions to reduce harm associated with adolescent substance abuse[1] is timely. The increase in alcohol misuse among adolescents is a highly discussed topic in Austria at the moment.

The number of patients admitted to our rural hospital with alcohol intoxication and the proportion of adolescent patients has increased slowly over the years. Nationwide data are similar.[2] But the main change we have seen is in media coverage: 10 years ago no public interest focused on a drunken adolescent, but now a 16-year-old with a blood alcohol concentration of more than 1 g/L can be sure to find his detailed story in the local newspapers the next day.

Because the number of cases is increasing and public interest is high, the Austrian Ministry of Health has decided to introduce colour-coded identity cards for adolescents as a measure to reduce the accessibility of alcohol. The colours are supposed to facilitate age determination in dimly lit clubs and bars. Adolescents younger than 16 years are not allowed to purchase alcohol; those younger than 18 may not purchase hard drinks. This measure is not unanimously approved of: it is difficult for many adolescents to understand that they have a right to vote at general elections at age 16 years but cannot decide what they drink at night.

Toumbourou and colleagues' paper is helpful in facilitating decisions in a field with a lot of public opinion and little convincing scientific evidence.

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The Oslo Ministerial Declaration

In a declaration on global health and foreign policy (April 21, p 1373),[1] seven ministers of foreign affairs take further the increased attention this topic has received in recent months.[2–5] The main message of this important initiative is that a country's foreign policy should primarily be judged by its effect on global health.

The declaration specifies important interventions related to health and health-care problems we face today, as well as to risks that need to be dealt with now to prevent problems in the future. However, how these interventions will be prioritised is not suggested. For example, it is not ethically defensible to postpone attention to the 500 000 women who die every year during pregnancy and childbirth and give higher priority to dealing with risks that might affect these families some time in the future.