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LETTER TO THE EDITOR

The European Society of Paediatric Radiology's position statement on point-of-care ultrasound

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Dear Editors,

We read with great interest the article by van Rijn et al. [1] on point-of-care ultrasonography (POCUS). While we commend their efforts on making this a European Society of Paediatric Radiology (ESPR) position paper, we have some concerns and comments. As the European Society of Paediatric and Neonatal Intensive Care (ESPNIC) POCUS Working Group, our intention is to promote collaboration between those paediatric radiologists and intensivists utilising POCUS.

First, although the term POCUS is used widely in the adult and paediatric world, van Rijn et al. [1] continue to debate it. Similar to adult specialties, we believe that POCUS can be performed by any appropriately trained clinician (i.e. by radiologists and non-radiologists alike) who wishes to provide high-quality patient care by understanding the pathophysiology, performing timely reassessments and performing procedures successfully and safely. Our notion is consistent with the position statement of the American Medical Association (AMA) on privileges for ultrasound (US) imaging, stating that US may "belong" to any and all medical specialties as long as certain standards are met [2].

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Second, we strongly agree with the closing remarks of the ESPR statement: POCUS should only be performed by competent operators within a systematic framework of regulations and expected standards. In ESPNIC's POCUS guidelines published in *Critical Care*, Singh et al. [3] emphasize that POCUS should be performed by intensivists for selected indications and under its limitations. POCUS is not intended to replace a formal assessment by the paediatric radiologist or cardiologist [3].

Third, our standpoint regarding credentialing and reporting is that a unique (non-traditional to radiology) approach should be adopted to promote use of POCUS for pre-defined indications while ensuring quality-assurance expectations such as certification policy, integration in daily practice, standardised POCUS guidelines, patient safety measures, robust clinical governance, imaging storage and reviewing, and continuous medical education (CME) related to POCUS.

Fourth, we do believe that it is a false perception that POCUS would systematically lead to misdiagnosis or increase the scanning burden for paediatric radiologists. On the contrary, some beneficial systematic effects of POCUS on radiology workload have been published [4]. There is enough literature demonstrating these assumptions in adult medicine and there is no reason to think that it would be different for children and neonates [4, 5].

Finally, 24/7 high-quality imaging by the paediatric radiologists and cardiologists remains a challenge, even in well-established children's hospitals in the Western world, especially during out-of-hours.

During the coronavirus disease 2019 pandemic, POCUS performed by trained general practitioners and in other prehospital care settings was well accepted [6–8].

We believe that POCUS has the potential to increase collaboration between paediatric specialties. In the near future, we would support constructive discussions between paediatric radiologists, cardiologists, intensivists and

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ESPNIC to mutually invest in pioneering the fundamental standards of European paediatric and neonatal POCUS [3].

Declarations

Conflicts of interest None

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