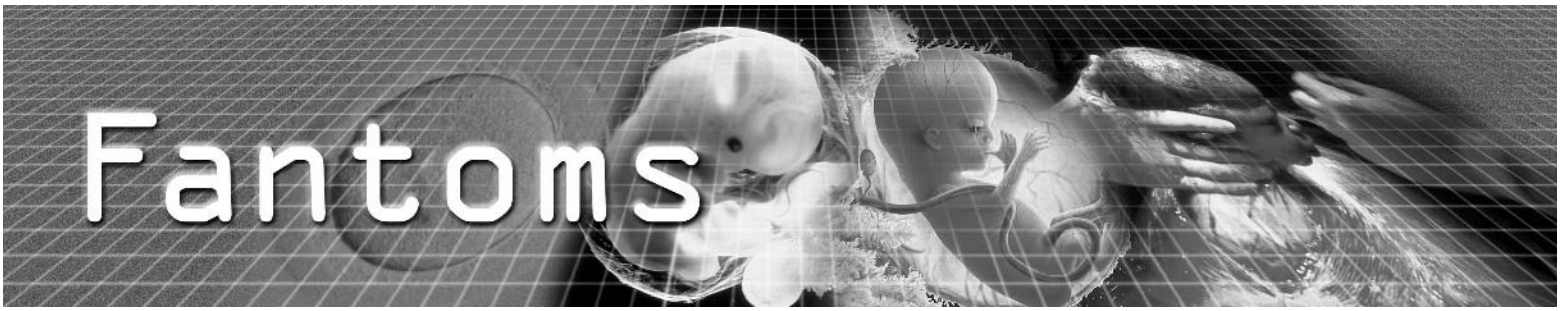

Ben Stenson, *Associate Editor*

OPEN OR SHUT CASE?

Despite much meticulous research we are essentially still in the dark on what to do about the patent ductus arteriosus in preterm infants. Should the medical treatment approach be prophylactic, symptomatic, or haemodynamic? Should surgical closure take place early, late, or not at all? Brooks et al describe their experience where duct surgery is not available and suggest that the time has come for trials to determine whether surgical closure after failed medical treatment confers any benefit at all. In a perspective on the subject, Fowlie reminds us that there is no evidence that any treatment of patent ductus arteriosus results in long term benefit and repeats the call for further definitive studies.

See pages 190 and 235

THE ASHINGTON EXPERIMENT

Hall and Wilkinson review the ''Ashington experiment'', in which a new neonatal service was set up, run entirely by Advanced Neonatal Nurse Practitioners (ANNP) with no paediatric medical staff on-site. They highlight the efficacy of the service and the benefits of a stable workforce as well as what has been learned about the numbers of ANNPs needed, the costs of training, the secondary costs of backfilling their nursing roles, and the levels of consultant support required.

See page 225

PARENTAL RESPONSIBILITY

How many times have you had to deal with concerns expressed by an ethics advisory committee about the number of research studies to which infants and their parents may be exposed in your unit? Morley and colleagues demonstrate that the parents are less troubled by this than the ethics advisory committees and feel comfortable dealing with this issue themselves. Many give positive reasons for wanting their children to be cared for in institutions where research is given a high priority and for enrolling them in studies.

See page 225

RETINOPATHY OF PREMATURITY

Haines *et al* report the findings of a UK population based study of severe retinopathy of prematurity (ROP). Of those that developed stage 3 disease, 59% were deemed to require treatment and 13% ended up with a severe vision deficit at 1 year as a result of ROP. This worrying proportion with poor outcome despite treatment demonstrates the importance of focusing on prevention as well as on improved screening and treatment. Epidemiological studies suggest that there is still much to learn about optimal oxygen therapy in this area and the recent funding of the Benefits of Oxygen Saturation Targeting (BOOST) II trial in Australia and the momentum gathering amongst similar collaborations in the UK, Canada, and the US offers the promise of considerable progress in this area.

See page 240

AIR OR OXYGEN?

One caution expressed by those concerned about the suggested use of air instead of 100% oxygen for initial resuscitation from asphyxia is that the required changes in pulmonary vascular resistance may not occur as reliably. Fugelseth and colleagues studied the issue in a neonatal piglet model of acute asphyxia. The use of 100% oxygen offered no benefit in terms of restoration of cardiac output or normalisation of pulmonary artery pressure after severe asphyxia.

See page 229

CEREBRAL FUNCTION MONITORING

Cerebral function monitoring is taking on greater importance now that it may become part of the clinical evaluation used to select infants for hypothermia treatment after asphyxia. de Vries and Hellström-Westas provide a timely review of the interpretation and use of the technology. van Rooij and colleagues describe the natural history of amplitude integrated EEG changes after perinatal asphyxia in relation to prognosis.

See pages 201 and 245