Martin Ward Platt, *Associate Editor*

HYPOTHERMIA, ACCIDENTAL

We touched on the prevention of hypothermia in the November edition (A-L Frannsson *et al*, *Arch Dis Child* 2005;**90**:F500–4): in this issue Green *et al* report the detection of cold babies in a community setting and the validation of a simple device for the detection of hypothermia in Indian urban slums. The device seems to perform well, and most of the hypothermia was found on the first postnatal day, just as Fransson *et al* would predict. Worldwide, this device could have great potential for the prevention of avoidable harm to newborn babies.

See page 96

HYPOTHERMIA, DELIBERATE

There has been huge interest in the potential of therapeutic hypothermia for the treatment of perinatal hypoxic-ischaemic brain injury. Animal work is supportive and encouraging, and the first reports from various trials are starting to emerge in the literature. But as with all such potential advances, enthusiasm may be running ahead of the science. Edwards and Azzopardi do us a two-fold service in their review: they dissect the outcomes of the existing trials in infants, and they go on to discuss the nature of therapeutic equipoise with reference to the introduction of this, or any other, new therapy.

See page 127

250 YEARS OF NEONATAL RESUSCITATION – OLD ANSWERS, NEW QUESTIONS

Peter Dunn draws our attention to the prescient writing of Dr Michael Underwood in the 18th century. In the resuscitation of babies, Dr Underwood emphasised the importance of airway and breathing ahead of circulation, and noted the ability of apparently lifeless babies to recover so long as their lungs were successfully inflated. Almost 250 years on, Trevisanuto *et al* in a survey of contemporary practice in Italy, found huge variations in practice in relation to the immediate management and resuscitation of the very premature baby. Some of these variations probably don't matter very much, either because the evidence is equivocal (how much oxygen?) or just not there (oral versus nasal endotracheal tubes). Some, such as thermal care, matter much more; but only 5 of 76 centres used an occlusive polythene bag for their babies even though it has been shown to be simple, effective, harmless, and extremely cheap.

See pages 123 and 150

''FLKs'' AND AEDs

There have been several publications in the last two or three years on the outcome of fetal exposure to maternal anti-epileptic drugs (AEDs). Kini *et al* have systematically analysed the dysmorphisms that are related to these exposures, and related these to other facets of the syndromes. Paediatricians need to know about the effects of AEDs from both ends: as neonatologists we see the babies, and need to know what to do with them and what to say to the parents. As paediatricians, our choice of anticonvulsants for adolescent girls with seizure disorders, and the counselling we give about the effects on future pregnancies, are just as important.

See page 90

THIS MONTH IN ARCHIVES

- Within the next three years, UK national neonatal screening for cystic fibrosis will be on stream. Those of us concerned with neonatal care need to familiarise ourselves with the basis and process for this new programme if we are to avoid some of the problems that have emerged in the current blood spot screening programmes. Price's perspective on Massie *et al*'s paper is extremely helpful in this regard. Programmes based around the needs of the majority (term babies) also need to be sensibly configured for the 7.5% of babies born <37 weeks.
- Detection of cleft palate at the newborn examination remains a controversial area. Habel *et al* correctly state that palpating for a cleft commonly fails to detect it. However, they conclude that visual inspection should be the primary mode of examination, whereas many neonatologists would reserve visual inspection for those babies in whom the posterior palatal spines cannot be felt – because if they can be felt, every kind of cleft is ruled out. Anyone feel like a rapid response?
- Nowhere in paediatrics will the importance of the Medicines for Children Network be more keenly felt than in neonatal care, so it is going to be important for all UK readers to have an understanding of this new initiative. Smyth and Edwards guide us through the rationale for the Network, and highlight both the achievements of the existing collaborations (the main examples for neonates being the National Perinatal Epidemiology Unit and the British Association of Perinatal Medicine), and the potential added value from the new Network.