Fantoms

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To splint or not to splint?

It has been my own experience, and I have observed it in others, that the amount of energy devoted to fixing an intravenous cannula is proportional to the difficulty of inserting it. So when a cannula is inserted in a vein such that it crosses a joint, it has been usual practice in many places to try to prevent movement of the cannula by splinting the limb, with the intention of prolonging its life. But does this work? Not according to Dalal *et al*, who randomised cannula insertions to 'splint' or 'no splint' and found no difference in the lifespan of the cannula. I can already hear the anguished dissent as everyone who 'knows' how important splints are insists that this cannot be true for cannulas in the foot/hand/antecubital fossa/popliteal fossa (select your preference). It is now up to anyone who believes that splinting is still appropriate for some specific location to prove it themselves—with an RCT, of course. ***See page F394***

Safe to repeat antenatal steroids

Giving one course of antenatal betamethasone when preterm labour is likely is well known to be a better strategy than not giving it. But the safety of repeating the treatment, if delivery has not occurred but still looks likely, is not so obvious. Peltoniemi *et al* report the outcome of an RCT in which women received a further single dose (of betamethasone or placebo) if they had still not delivered one week after the first course, and find no differences in neurodevelopmental outcome between the two groups at two years. This is an important negative finding that is actually a positive result; the only difficulty is that because of the generous inclusion criteria (up to 34 weeks), many of the babies were relatively mature and big, so any adverse effect among the most vulnerable babies under 28 weeks might have been masked. ***See page F402***

Survival in Switzerland

Fischer *et al* make a compelling case that the introduction of guidance for the management of babies at the limits of viability may well have had the effect of improving survival in Switzerland. Their use of international comparisons is perhaps the strongest evidence against this being merely an artefact of gradual improvements in survival that were taking place anyway. It also illustrates that a negative view of outcomes can become a self-fulfilling prophecy, and conversely that higher expectations can lead to better care. ***See page F407***

End of life care in Holland

Our Dutch colleagues Verhagen *et al* have bravely confronted the issue of drug use when babies make the transition from active intensive care to palliation. They do this perhaps more openly and honestly than is usual, or possible, in other jurisdictions. They report a high rate of opioid and benzodiazepine use, very much in line with good practice in end-of-life care in any age group. Most strikingly, they found that neuromuscular blockers were used as part of palliative care in around one in six instances, for reasons such as the prevention of additional suffering among babies already receiving such agents, to stop or prevent gasping, or on parental request. In the UK, and perhaps elsewhere, I suspect that the administration of such agents to a baby not already paralysed would be much less likely because it is more difficult to justify the use of neuromuscular blockers on the basis of 'double effect'. This paper will be read with interest around the world, and is likely to cause some debate—see our Letters page. ***See page F467***

Hanging around in hospital

One of the major determinants of both the cost of caring for premature babies, and the throughput of a neonatal service, is a baby's length of stay in hospital. Altman *et al* have chosen to study near-term babies rather than very premature babies, and have examined the determinants of length of stay as well as the variations between different hospitals. It is interesting that for this group of babies (32—34 weeks), the various perinatal factors relating to illness don't seem to account for much of the inter-individual variations in length of stay—rather, the variations between services seem to have a great deal to do with their organisation of care. No surprise, then, that some of the shortest lengths of stay were seen in those services with well developed domiciliary support services. A message here, perhaps, for any neonatal services struggling with problems of capacity. ***See page F414***

Our orphan Perspective

For reasons too complicated to explain, we have ended up publishing in this edition a Perspective, on the toxicity of apparently inert additives and excipients to neonatal medicines, three months after the original article by Whittaker *et al*[1] was published. I appreciate that this rather defeats the main aim of a Perspective, which is to point to a paper appearing later in the same edition and add value by setting it in a larger context. I therefore owe it to the authors and the readership to highlight that the potential toxicity of additives is a new aspect of medicines in the newborn that goes well beyond the licensing and labelling considerations, and emphasises the need for manufacturers to give attention to possible toxic effects to which they may not usually give consideration. Apologies to all concerned.

Reference

1. **Whittaker A,** Currie AE, Turner MA, *et al*. Toxic additives in medication for preterm infants. Arch. Dis. Child. *Fetal Neonatal Ed*. 2009;**94**:F236–40.