CAFFEINE FOR LATE PRETERM INFANTS?
Elizabeth Oliphant and colleagues report the outcomes of a double-blind placebo controlled randomised dosage trial of caffeine for late preterm infants. Their focus was on finding a suitable dose to prevent intermittent hypoxaemic (IH) events between 34 weeks gestation and term equivalent age in infants born between 34⁺⁰ and 36⁺⁶ weeks gestation. Intermittent hypoxic events were defined as falls in SpO₂ of 10% or more lasting less than 2 min. Four dosing regimens were evaluated. Compared with placebo, IH was significantly reduced in the combined groups of infants treated with caffeine. There were variations in observed effects between individual dosage groups, so that effects were statistically significant in some but not others. The authors argue that the 20 mg/kg/day dose would be the best for further evaluation. There was a small reduction in time with SpO₂ <90% and a small increase in baseline SpO₂. Important adverse effects were not identified but the total number of infants studied was 132, so there was limited power to identify infrequent events. The authors are interested in determining whether reducing intermittent hypoxaemia during these weeks might be associated with later neurodevelopmental advantages and hope to conduct a large RCT to test this hypothesis. In the Caffeine Therapy for Apnoea of Prematurity Trial, the benefits shown in more immature infants were observed with treatment that ceased at around 34–36 weeks corrected gestational age, so if there were benefits to this treatment demonstrable in late preterm infants the question would arise whether caffeine should be continued until term in less mature infants too. I hope that the study design will consider this. See page F106.

MANAGEMENT OF PNEUMOTHORAX IN NEONATAL RETRIEVAL
There is variation in practice regarding the treatment of pneumothorax, with some preferring needle aspiration as a first approach, rather than drain insertion. In the neonatal unit both options are provided easily and drainage can be performed if aspiration proves insufficient, but in neonatal transport the challenge of drain insertion should it be required is greater. Ikhwon Hallibullah and colleagues report the experience of the Paediatric, Infant and Perinatal Emergency Retrieval (PIPER) service based at the Royal Children’s Hospital (RCH), Victoria, Australia with the management of infants referred for transport between 2016 and 2020, who had pneumothoraces. There were 174 infants included in the report. A chest drain was inserted in 82 (47%). There were 95 infants treated with needle aspiration and 40 of them subsequently avoided a chest drain. No infant required a chest drain or a needle aspiration during transport. None of the 12 infants transported by air without a chest drain deteriorated during transport. The data suggest that selected infants with pneumothorax who require transport can be transported safely without chest drain insertion, shortening stabilisation time and avoiding chest drain insertion altogether in a significant number. See page F182.

CHEST COMPRESSION RATES DURING CARDIOPULMONARY RESUSCITATION
Some clinical uncertainties regarding resuscitation will be particularly difficult to resolve with high quality studies in human infants due to their rarity and urgency. The present recommendation for cardiopulmonary resuscitation in the newborn is that compressions should be provided at around 90 compressions per minute. This is a lot slower than the heart rates observed in sick infants and is based on extrapolated information and pragmatic assessment of how efficiently they can be delivered. Marlies Bruckner and colleagues studied the effect of different compression rates on cardiac output in term piglets that had been asphyxiated to asystole. Compressions were delivered by an automated machine and compression rates from 60 to 180 beats per minute were studied. There was a progressive increase in stroke volume and cardiac blood flow up to a compression rate of 150 beats per minute and an increase in cardiac output and blood pressure up to a compression rate of 180 beats per minute. The data suggest a need for further exploration of the best approach to neonatal cardiopulmonary resuscitation. See page F200.