ambulance service trust involved. By law the trust was liable for employees involved in accidents while on duty, but nevertheless the recourse to obtain compensation was through the mechanism of long delays.

As a result of our experiences we have undertaken a comprehensive review of our neonatal transport operations. Initial problems of incubator security have been temporarily addressed with ring bolts set into the floor of ambulances which allow secure anchorage with cargo straps. Incubators are loaded using portable rams. In the long term, in cooperation with our ambulance service, we have redesigned our transport system with a reduced payload around a no lift platform that will be compatible with all types of stretcher. The ambulance service has also undertaken to modify ambulance anchorage to accommodate newer stretcher types with transport incubators on board.

The standards of safety for neonatal transport incubators need to be reviewed. Attention needs to be given to reducing payload, and to the long-term interest in the safety and security of incubators within ambulances, whether road vehicle or aircraft. The problems of different incubators, ambulances, and stretcher designs can be avoided by using a universal mounting plate. Each unit needs to be aware of its responsibilities to its staff regarding liability in the event of an accident.

Unfriendly incubators

Editor.—Fractures in infants of very low birth weight (<1500 g) not related to birth trauma are being recognised with increasing frequency.1,2 These fractures are usually associated with bone demineralisation, which is frequently present in very low birthweight infants,3 and almost two thirds of them involve the extremities.1 Fractures in these infants can occur as the result of ‘trauma’ during physiotherapy or other procedures such as placement of intravenous lines.1,4

We have observed four infants with birth weights under 1000 g who sustained traumatic fractures of the extremities (one arm in three cases, one leg in the other), and we believe that the contributing factor was accidental manipulation of the extremity by or under the plastic tray on which the mattress of the incubator lies. The fractures, diagnosed radiologically between 4 and 6 weeks of age, were confirmed with similar osteoporosis. Two of these babies also had well documented bone demineralisation. Subsequent to these independent observations in Athens and Montreal, we conducted a survey of incubators used in neonatal intensive care units and found that in many (even in some of the latest models) there was sufficient gap between the plastic tray and the incubator wall for an arm or a leg of the baby to slip between the incubator’s wall and the plastic tray (figure). In many instances the nursing staff had tried to cover this gap with rolled sheets. In some incubators the tilting mechanism could not be securely locked at the desired tilted position as grade II plus the need for respiratory support. Data was collected by two independent visiting observers. The last three years of complete data were analysed (1 April 1990–30 March 1993).

There were a total of 168 435 live births in 16 perinatal centres (five subregional units and 11 smaller units) and 263 babies with HIE; 141 grade II and 122 grade III (table). The incidence of HIE for the region was 1·56 per 1000 live births (range 0·58–5·1 per 1000 live births). The Doncaster unit (number 6 in the table) had an incidence of 1·53 per 1000 live births— that is, similar to the region as a whole.

It is clear that criticisms levelled at this perinatal unit were unfounded and based on anecdotal evidence rather than fact. Data relating to HIE is not routinely collected by most perinatal units, however, we believe such data provide a valuable method of monitoring neonatal care. Only if the rate of HIE falls outside the ‘normal range’ is concern warranted.

Excessive rates of asphyxia—accedent or fact?

Editor.—It is well known that hypoxia ischaemic encephalopathy (HIE) in neonates is associated with adverse neurological outcome.1,2 The incidence of HIE can be a useful indicator of quality of intrapartum care provided to term infants,3 while the severity relates to subsequent neurological outcome.2 The Doncaster perinatal service has received much adverse publicity suggesting that their incidence of HIE was excessive (‘Trial of labour’, World in Action, Granada Television, 2 Nov 1992). We analysed data from the Trent Regional Neonatal Survey in order to establish these criticisms were valid.

The Trent Regional Neonatal Survey collects data on all high risk babies admitted to perinatal units within the region. All babies greater than 35 weeks’ gestation admitted because of HIE were included in this analysis. HIE was diagnosed using modified criteria of Levene et al.4 Grade II HIE was defined as the infant having a history suggestive of asphyxia plus convulsions, while grade III was defined as having grade II plus the need for respiratory support. Data was collected by two independent visiting observers. The last three years of complete data were analysed (1 April 1990–30 March 1993).

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Diagnosis and management of non-immune hydrops in the newborn

Editor.—We read with interest the article by Stephenson et al on the diagnosis of non-immune hydrops in the newborn,1 and we would like to emphasise that a wide range of inborn errors of metabolism (IMD) have been reported to be associated with non-immune hydrops and in many cases a feasible pathogenetic mechanism can be hypothesised.2 As a cause of hydrops they are rare

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