complications were observed.³ I agree strongly with the authors² that inadequate stabilisation before transportation is the principal cause of complications during transfer. We have documented the time taken for stabilisation in 2863 neonatal and paediatric patients.⁴ The median stabilisation time for a neonate was 80 minutes and for a paediatric patient was 45 minutes. The time for stabilisation of a neonate reported by the Nottingham group¹ of 75 minutes is comparable with our experience.⁴ This is time very well spent. Unfortunately, a common but deplorable approach to transport reflecting an attitude of 'get that patient out of here' is very common and detrimental to patient safety during transport. This attitude of so called 'swoop and scoop' with inadequate time spent on stabilisation is rarely if ever appropriate in interfacility transfer of sick patients. There are those who claim 75–80 minutes spent stabilising a sick newborn before transfer is unnecessary – the so called (and cynical) 'stay and play' philosophy. I disagree with this. Rather stay and play and be assured a thorough stabilisation than swoop and scoop with serious but avoidable problems during the transfer.

An in-depth, very practical, and helpful revision of the 1986 American Academy of Pediatrics guidelines for air and ground transportation of paediatric patients has been recently published⁵ and is highly recommended for all facilities engaging in paediatric and neonatal transport.

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Prediction of chronic lung disease (CLD)

EDITOR,—We enjoyed reading the recent article by Ryan and coauthors on the prediction of chronic neonatal lung disease (CNLD).¹ At our own unit, using a database of all babies of <2.5 kg requiring ventilation, between 1980–1990, we derived a similar type of score using independent variables including sex, duration of exposure to FiO_2 of >0.6, and duration of exposure to a peak inspiratory pressure >25 cm H_2O .² We validated our own score by dividing the study population into a training set used to derive the score, and a test set for evaluation of sensitivity and specificity. Our sensitivity of 65% and specificity of 88% at a cutoff of $p \geq 0.50$ are lower than those of Ryan *et al* (73% and 93%, respectively).

As early intervention such as steroid treatment before 12 hours³ or between 12 and 18 hours⁴ may reduce the incidence and severity of CNLD, a predictive test that can be

calculated soon after birth is required. Unfortunately, neither our score nor that of Ryan *et al* are useful in this regard, as our score could not be calculated before the fifth day of life, and Ryan's score cannot be calculated till the seventh day.

The OSECT study (Open Study of Early Corticosteroid Treatment) is recruiting very preterm infants who have severe respiratory distress within the first 72 hours of life and it should demonstrate the value or otherwise of early treatment with systemic or inhaled steroids. It is hoped that this study will also provide further data for early prediction of CNLD. Anyone interested in further details of this trial could contact the authors at the address below.

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