

Fantoms

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CONSENT . . . AGAIN

In the last edition of *Fetal and Neonatal* we carried a leader on obtaining consent for neonatal research. We follow that up with some important data from Canada, and a further commentary on the subject. Although it is tempting to view parents with ill babies as less than competent to give truly informed consent, the parents who participated in this study both acknowledged the added stress of considering enrolment into studies, and most importantly were willing for their child to participate in more than one study. Since many ethics committees insist that parents should not be asked for enrolment into more than one study, on the grounds of preventing distress to the family, these data need to be seen more widely than just the community of neonatal doctors and nurses. Commenting on these data, Alan Fenton makes the point that the experience of parents whose babies are enrolled in studies is in itself an important outcome, and we should be auditing it routinely if our research and consent protocols are to be of the highest quality.

See p 280, 286

IMAGING THE NEONATAL BRAIN . . . AGAIN

Also in the last edition, we published a paper from Sheffield evaluating low field strength magnetic resonance imaging (MRI) of the neonatal brain, comparing the clinical data and the economics of this with cerebral ultrasound. In this issue we carry a review of MRI, which unfortunately could not take account of the Sheffield work by virtue of its timing; and a paper from Nantes that directly compares the sensitivity of ultrasound against MRI in diagnosing white matter lesions. Not surprisingly, Debillon *et al* showed that early ultrasound appearances were a particularly poor predictor of MRI appearances at term, as compared with early MRI appearances. In contrast to the Sheffield study, MRI

examinations were confined to relatively healthy babies because ill ones could not be scanned in their equipment, so it will be important for a study with a similar design to be undertaken for low field strength MRI in the sicker babies.

See p 269, 275

WEANING

Of all the advice to parents given by paediatricians, general practitioners, dieticians, health visitors, and children's nurses, the timing of the introduction of solid food for infants is the topic based on the weakest of evidence. We already know that what professionals recommended and what parents actually did were completely different between the mid 50s and the mid 80s,¹ and Fewtrell *et al* in this issue extend these observations into the 90s. This might suggest to the disinterested observer that paediatricians need to imbibe a combination of evidence and humility if they wish to become truly helpful to their patients. For babies who are born preterm there is the added spice of deciding whether actual or corrected age is the more appropriate basis on which to introduce solids. So the second paper on weaning that we carry, a randomised controlled trial of a "preterm weaning strategy" from Southampton, is both timely and important. The strategy showed clear benefits in terms of improved growth and iron status, and should be food for thought for all those who supervise the progress of preterm babies after they have left hospital.

See p 296, 302

LONG LINES

The deaths of four babies from cardiac tamponade associated with percutaneous central venous lines were the subject of a Department of Health review (published in 2001). The public gained the impression from the press that this complication was not only well known, but also common, and that percutaneous long lines were inherently dangerous especially if their tips were placed in the right atrium. The report acknowledged the lack of sound epidemiological data on the complication rate for central venous lines of this kind, so it is useful that Beardsall *et al* have attempted to arrive at an estimate of the frequency of this complication based on something a little more scientific than a finger in the wind. Even so, it is still likely that they underestimate, since complete ascertainment can seldom be secured and the denominator is not particularly robust either. Perhaps the National Patient Safety Agency may prove a better route for the ascertainment of rare complications of long lines; alternatively a study using the British Paediatric Surveillance Unit could be the way forward.

See p 260, 292

FEVER IN HEALTHY TERM BABIES: SHOULD WE BE A BIT MORE RELAXED?

Babies who become a bit too hot get cold comfort from conventional management. They are commonly attacked for blood samples, find themselves with a cannula in a vein, and receive antibiotics for variable lengths of time. If they are seriously unlucky they get a lumbar puncture too, and they may find themselves separated from their mother by being taken to special care. So it is good to read a paper challenging our conventions. The case control study from Israel suggests that fever in the first postnatal days is commonly due to almost anything but bacterial infection, and only one in 122 babies in this study proved to have bacterial infection of a sterile site. These data should be good news for febrile babies, but I suspect that the results will need to be confirmed on a larger scale, and in other settings, before most units gain the confidence to change current practice.

See p 312

REFERENCE

- 1 Paul AA, Davies PSW, Whitehead RC. Infant growth and energy requirements: updating reference values. In: Walker AF, Rolls BA (eds). *Infant nutrition*. London: Chapman & Hall, 1994.

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