Fantoms

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SARS

Diligent readers of their newspapers may have noticed that during the height of the SARS epidemic, there were occasional references to its impact on pregnant mothers and their newborn babies. Many *Archives* readers probably wondered how it felt to be a neonatal paediatrician among all this. In this issue, our colleagues in Hong Kong tell us how they handled the problems with which they were confronted. They perhaps adopted measures which, with hindsight, might appear extravagant and perhaps unnecessary, but who among us would have done otherwise when faced with an epidemic infection in clinically uncharted territory? At present the WHO believes that SARS is under control, yet we cannot be certain that it will not reappear in China, Hong Kong, or elsewhere, and any of us may yet be grateful that Professor Ng and colleagues have beaten the path for us.
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LESS BIRTHS . . . BUT MORE INEQUALITY

In the UK we have all noticed that the progressive decline in the birth rate over the last 12 years has not affected the relentless rise in NICU workload, which is up by around 10% over the same time. Less obvious has been the fact that the reduced birth rate has not affected all strata of society equally, and Bundred *et al* have performed an important service by showing that in the Wirral, the reduction was greatest in the more affluent parts of society, and has been much less marked among the more deprived. The authors also highlight increasing social inequality in terms of birth weight standard deviation scores. What does this mean for the future? I suggest that if the present fashion for few or no children persist among more affluent families (who are at least risk of adverse perinatal outcomes) then reducing perinatal and neonatal death rates will become harder to achieve. Conversely, if the demographic pendulum swings the other way, we will all take the credit for improvements in these rates that would have happened anyway. And if neonatal services are stretched against a background of falling birth rates, what will happen when birth rates start to increase again? I can leave this to your imagination.
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LESS INTUBATION . . . BUT LESS EXPERIENCE?

The Advanced Life Support movement came into neonatal medicine on the back of clear evidence from children and adults that a systematic, decorticate (ABC) approach to collapsed patients is the most effective way to ensure a good outcome. Irrespective of the size of the patient, the immediate emphasis is on effective airway management, tracheal intubation being but one of a range of options. If this approach is an effective one in babies, one would expect to see a reduction in intubation rates at neonatal resuscitation, and the data from Allwood *et al* are consistent with this hypothesis. One salutary comment is that the changes documented in the paper " . . . occurred despite reduced experience of neonatal resuscitation by individual doctors in training consequent upon changing patterns of junior doctors' working hours." Ten years ago a paediatric senior house officer could be reasonably certain that after covering a busy delivery suite and neonatal unit for six months, he or she would be fairly proficient in endotracheal intubation. Is this still true?
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LESS DEXAMETHASONE . . . BUT WHERE DO WE GO FROM HERE?

"Neonatologists are using much less dexamethasone." The title says it all, and there are no surprises—I think we would all agree, but it is good to see the gut feeling quantified. The drive to use less dexamethasone has been fuelled by greater awareness of its potential harms, and in particular the concerns about adverse effects on neurodevelopment. At the same time the whole point of using postnatal steroids is to save lives and reduce respiratory disability. So is there a danger of throwing out the preterm baby with the bathwater? If we neonatologists look over our shoulders at our obstetric colleagues, we see that they have got there before us. There is now sufficient good evidence that betamethasone used antenatally is safer for the infant brain than dexamethasone that the Royal College of Obstetricians and Gynaecologists explicitly recommends the use of betamethasone for antenatal use. So: is beta- better for preterm babies postnatally? I think we ought to know.
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PARENTS AND POST-TRAUMATIC STRESS DISORDER

Earlier on the day of writing this, I was teaching a small group of medical students. Two of the mothers on the unit told them how it was in the first week of so of their babies' postnatal life. "Hell" was a word that both of them used. Though the students were a little surprised, we should not be. We know that all parents find neonatal care incredibly stressful, and it appears that a few will go on to show features of post-traumatic stress disorder (PTSD). In those who do, we should not be surprised that it may affect the way they look after and relate to their child after discharge from hospital. Pierrehumbert *et al* have shown that this dimension of parental coping, or failure to cope, does indeed have an effect. Whether interventions to identify and modify PTSD in parents might be feasible or effective remains to be seen, but at least the question has been posed.
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