EUTHANASIA

Here is an uncomfortable word that in neonatal medicine we prefer not to use. We commonly use the term ‘withdrawal care’—a terrible thing to say when we actually mean moving from intensive to palliative care. While some of us commonly use the term ‘palliative care’, we all accept that discontinuing intensive therapy usually—but not always—leads relatively soon to death. We smooth the path of palliation with medication to alleviate suffering—but we don’t kill, or at least we don’t intend to do so. Probably. Now Cuttini et al. have grasped the nettle of euthanasia as a legalised entity, and explored how medical and nursing attitudes vary across 10 European countries to this possibility. They found very large differences in attitudes between different countries, with the Netherlands and France being outliers in the direction of active euthanasia, while the UK sits much closer to those countries like Germany and Lithuania, where there seems little enthusiasm either for active euthanasia or for changes in the law. I don’t know whether to regard their findings as positive or negative, reassuring or sardonic. The sardonic irony with which the poem was written, I reproduce it in full below.

See page 19

STRESS, PAIN & THEIR RELIEF

I get uncomfortable when ‘Fetal and Neonatal’ seems to be entirely dominated by Neonatal, so it is with great personal satisfaction that I note that this issue has several papers that cross the Great Perinatal Divide. One of these is the paper by Gitau et al., who examined fetal stress responses to intrauterine transfusion. As the authors acknowledge, work such as this begs at least as many questions as it answers, and the focus on the hypothalamic-pituitary axis avoids the rather obvious questions — does it matter and what can we do about it? Pain does matter, of course, and it is good to be able to carry a paper that should help us to use rationally a potentially important intravenous analgesic, propacetamol (a pro-drug of paracetamol). Allegaert and her colleagues have done a useful service in providing some data on which to base dose strategies, but we still await better methods of assessing the efficacy of analgesia in the neonate.

See pages 25 and 29

METHADONE AND BABIES

Knowing that the side effect profile of any opioid is very different in humans according to the degree of pain for which they are being treated, I have always wondered whether babies would react in the same way to withdrawal from opioids used for maternal analgesia as from the same drugs used in harm reduction programmes. Now we have something of an answer to this: Sharpe and Kuschel suggest that where mothers have received methadone as treatment for chronic pain, their infants have less withdrawal symptoms. But were many of the mothers on harm reduction programmes taking lots of other stuff, making their babies more symptomatic because of that? There’s a lot more we need to know about this increasingly prevalent problem.

See page 33

MEASURING INTRAPARTUM CARE, & CESDI 27/28

Pain and methadone are both fetal and neonatal problems—so is intrapartum care, and we have three takes on this in the current issue. First, we have an annotation that explores the challenges presented to neonatologists by the report from the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), which published its investigation into the perinatal care of babies born at 27 and 28 weeks in 2003. Second, we have a research letter from Edinburgh that presents a solution for the problem of early thermal care for these babies, which was one of the issues highlighted in the report. Finally, we have a paper that tackles the thorny issue of the structure of perinatal care and its relation to stillbirth and neonatal death: it suggests that a more interventionist obstetric approach, and units that have more consultant input, see better rates of stillbirth and neonatal death. In contrast, paediatric variables seemed to make little difference to neonatal outcomes. These data from Joyce et al. complement those from confidential enquiry that have appeared in CESDI reports over the years.

See pages 14, 41 and 44

FINDING THE TIP OF THE LONG LINE – HUNTING THE SNARK?

So many attempts to find the tips of long lines, such variable success. We badly need to know where the tips are, and where they aren’t—but no one has come up with a foolproof way of achieving this. The approach reported by Evans et al. seems to beat that from Odd et al., but as yet not many neonatal units have access to radiographic ‘soft copy’ as provided by computed radiography, so most of us struggle on with old tech from Odd et al., but as yet not many neonatal units have access to radiographic ‘soft copy’ as provided by computed radiography, so most of us struggle on with old tech.

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See pages 14, 51 and 93

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