

# Fantoms

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## COMPULSORY READING

The report by Manning *et al* of a prospective surveillance study of severe hyperbilirubinaemia in the newborn in the UK and Ireland and the provocative Perspective by Ives should be read by all. Whether you call it severe, extreme or hazardous (probably all three), bilirubin levels exceeding 510  $\mu\text{mol/l}$  were observed in at least 7.1/100 000 infants. Bilirubin encephalopathy and kernicterus should therefore be a renewed concern for all who care for newborn infants in the UK and Ireland. The majority of cases were identified after discharge from hospital. This highlights the need for appropriate post-discharge review and requires difficulties with measurement of bilirubin after discharge to be overcome. Although many affected infants had characteristics that identified them as at greater risk, such as haemolytic disease, the absence of risk factors in many cases and the common association of severe hyperbilirubinaemia with exclusive breast feeding and dehydration have led some to label this “lack of breast milk jaundice” or, darker still, “lack of formula milk jaundice”. Adequate support and review of breast feeding mothers and their infants in the community is clearly an important issue. The management of the infants reported was highly variable and reflects the absence of guidelines in the UK. Ives suggests that it is no longer accepted practice to subtract the conjugated element when managing hyperbilirubinaemia. This is consistent with the American Academy of Pediatrics Clinical Practice Guideline, although the guideline does not offer evidence in relation to that recommendation.

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## POSTNATAL STEROIDS

Eichenwald and Stark ask whether postnatal steroids should ever be given to infants with bronchopulmonary dysplasia. They remind us of the association of postnatal steroids with adverse neurodevelopmental outcome and show data from the Vermont Oxford Network indicating that around 8% of very low birth weight infants still receive them. They suggest that their use may be justified, but only in the sickest infants and provide some hypothetical treatment criteria. These would certainly not apply to 8% of infants and this reflects the inconsistency between the caution against steroids expressed in guidance and the extent to which they are still prescribed in the real world. Now that the response to the follow up data has passed, with steroids still being prescribed so widely, it should be possible to conduct the trials needed to resolve the issue.

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## BACK TO SLEEP

In preterm and low birth weight infants, prone or side sleeping after discharge increases the risk of sudden infant death syndrome with an odds ratio of between 37 and 140 compared with supine sleeping. Kassim *et al* discuss the conflicting messages given to parents because preterm infants in the nursery are so often nursed prone even quite close to discharge to obtain the improvements in respiratory function observed in the prone position. They demonstrate that these are unlikely to be relevant beyond 32 weeks postmenstrual age in infants breathing air and recommend that infants in nurseries should be nursed supine in the weeks before discharge to transmit the safest message to parents. Poets and von Bodman have the same perspective.

See pages F331 and F347

## NITRIC OXIDE

Subhedar reviews trials evaluating the use of nitric oxide in preterm infants. There is little to suggest that nitric oxide will improve the outcome of severe respiratory failure but recent evidence raises the possibility that low dose nitric oxide administered prophylactically may reduce death or bronchopulmonary dysplasia and brain injury in some subgroups of infants. There is too little data on long-term outcome in terms of safety and efficacy to recommend routine use at this stage and a further large (800 patient) European trial is in progress.

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## GENETIC VARIATION

Harding reviews the increasing volume of data linking common genetic variation with neonatal disease and outcome. Knowledge in this field is advancing rapidly. Many of these genetic variations have potential effects on outcome at least as large as those attributable to interventions in clinical trials and may determine responses to treatment. Trialists are encouraged to make arrangements to store genetic material from trial participants to facilitate future pharmacogenetic interrogation of trial results.

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