Discontinuation of neonatal resuscitation in term babies

Dr Richmond helpfully reiterates current advice that discontinuation of appropriate resuscitation at 10 min in the absence of signs of life is justifiable due to the poor prognosis (both for survival and neuro-developmental outcome). A more difficult situation, on which there seems to be no guidelines, is that of the baby who shows no signs of life other than return of cardiac output. If a baby remains completely flaccid and has no breathing movements at, say, 20 min despite restoration of cardiac output before 10 min, the neurodevelopmental outcome is likely to be similarly grim. In this situation some practitioners will give 100% oxygen without ventilation for a period of time to ensure an adequate pCO₂ for respiratory drive while maintaining oxygenation. Others will remove the baby to a special care baby unit and place them on a ventilator for further assessment. In this case, breathing and some movements may appear after some hours, by which time the Rubicon has been crossed. Justification of such an approach is given in some texts on mandatory ventilation.

Corrections


doi:10.1136/adc.2007.118117corr1

P J McNamara and A Sehgal. Towards rational management of the patent ductus arteriosus: the need for disease staging (Arch Dis Child Fetal Neonatal Ed 2007;92:F424–F427). In class E5 of table 1 IVRT should read 40–50 (not 50–60) and IVRT of class E4 should read <40 (not >60).

doi:10.1136/adc.2005.092478corr1

C Booth, M H Premkumar, A Yannoulis, et al. Sustainable use of continuous positive airway pressure in extremely preterm infants during the first week after delivery (Arch Dis Child Fetal Neonatal Ed 2006;91:F398–F402). In table 3 of this article CMV is incorrectly defined as cytomegalovirus; the correct definition is continuous mandatory ventilation.