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## *Fetal and Neonatal this issue*

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### **Twins: more than twice the trouble?**

The incidence of twinning is rising, and we are all seeing more of the complications. Twins make up about 20% of all babies in many preterm cohorts; about a half of all twins are premature. The annotation by Chiswick (page 165) provides a characteristically helpful and thoughtful commentary on the two original articles which follow. Hopefully the message that the neonatal criteria which are used to diagnose twin-twin transfusion syndrome (TTS) are inaccurate and underdiagnose the problem is not new to readers of the Archives, who will read the paper of Seng and Rajadurai with this in mind (page 167). Nevertheless, their distinction between acute and chronic TTS may prove to have some implications for management. Cincotta and his colleagues from Brisbane add to their previous contributions to the literature on TTS (page 170). Of 17 pregnancies complicated by TTS which were diagnosed early in pregnancy (the first trimester) 29 babies were liveborn between 23 and 36 weeks of gestation and no pregnancy was prolonged beyond this gestation in the two year period of study. There were a further six neonatal deaths, and three of the 23 survivors developed periventricular leukomalacia, all evolving postnatally. These three children, plus another two, had cerebral palsy or neurodevelopmental delay at two years. These results were disappointing compared with those of the control group, made up of gestationally age matched twin pregnancies uncomplicated by TTS.

Improving outcome for fetuses affected by TTS in the middle trimester of pregnancy remains a formidable challenge for perinatal medicine. Cincotta *et al* speculate that there may be a difference in neurodevelopmental outcome following the two current methods of treatment for this condition in pregnancy (laser ablation or serial amnioreduction). We will all watch the progress of the European trial ([www.eurofetus.org](http://www.eurofetus.org)) with interest.

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### **More on the possible dangers of steroid treatment**

A further contribution to the important recent debate about the potential problems of early postnatal dexamethasone treatment is provided by Shinwell and colleagues from Israel (page 180). These researchers followed up a cohort of 248 preterm (< 2 kg) infants previously reported in Archives. Half of the trial group were treated with dexamethasone for three days and treatment began less than 12 hours after birth. Steroid treatment given this way proved ineffective against chronic lung disease. At follow up 51/159 of the infants had cerebral palsy; 49% of the treated group and 15% of the placebo group. This very high cerebral palsy rate is itself cause for concern. Most of the babies with cerebral palsy had PVL but 22% of the dexamethasone treated group had "ultrasound negative" cerebral palsy, and the authors wonder about the

potentially neurotoxic role of the sulphite preservative used in dexamethasone. Older neonatologists will shudder at the allusion to the toxicity of benzyl alcohol used as a preservative, which had such devastating effects many years ago. Whitelaw and Thorsesen discussed their concerns about multiple courses of antenatal steroids in the last issue (*Arch Dis Child Fetal Neonatal Ed* 2000;**83**:F154-7). They also touched upon differences between steroid preparations, referencing animal literature which ascribes the contrast to differences in molecular structure; possible effects of the preservative was not mentioned. Clearly it behoves all of us to follow this literature with care over the next year, and in the meanwhile parents have a right to be informed of the potential adverse effects as well as the undoubted benefits of postnatal steroid treatment.

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### **The newborn male disadvantage**

Stevenson *et al* remind us that this effect persists, and remains unexplained. They have no new theories, but point out that the difference in mortality between male and female infants of birthweight < 1500g is still 7%.

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### **Leptin in babies**

The product of the recently identified obesity gene, leptin, was measured in babies of diabetic mothers and preterm babies in Hong Kong (pages 198 and 203). There was no difference in the levels of leptin between IDMs and controls, but preterm babies had rapidly falling levels over the first five days. Female babies have more leptin than males. Whether this difference is cause or effect in female body fat distribution is not clear. Endocrinology has always been under researched in neonatology and may help to solve the riddle of the adult female body habitus, if not the newborn male disadvantage.

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### **Neonatal screening for hearing impairment**

Universal neonatal screening for hearing impairment is coming in the UK: it has been endorsed by the present government, and a further feasibility/pilot study is planned to start this year. The benefit of early diagnosis, which is followed by better speech and language development, is well established. The downside is the worry caused by false positive results, the cost and the learning curve. In this month's ADC, Kennedy gives a balanced view of all the issues, and forecasts the demise of the current distraction test carried out by health visitors at 7-8 months (*Arch Dis Child* 2000;**83**:377-83). The yield is likely to become negligible once universal neonatal screening is in place.

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