

Fantoms



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OPEN DUCTS, OPEN QUESTIONS

F&N could be accused of being obsessed with the arterial duct, in view of the space we have given in recent months and years to papers about its effects, strategies for its closure, and the competing claims of indomethacin and ibuprofen. The papers submitted to us indicate the importance of the issue to our readership, so we make no apology for commissioning reviews and perspectives to augment the debate about this important and persistent clinical problem. This month, we have both a thought provoking review by Bose and Laughon on the inadequacy of the evidence base for duct closing strategies, and a linked perspective by McNamara and Sehgal. I would also like to draw your attention to another *Archives* paper that can be found in Online First,¹ and a paper by Chorne *et al* on ducts and neurological morbidity in *Pediatrics*.² In the July Fantoms I wrote: "What we need now are some well-constructed randomised trials of different strategies for duct closure – including conservative management." At the risk of sounding like a scratched vinyl record, my message hasn't changed.

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FUNGI AND BACTERIA

Like the arterial duct, the problem of infection is always high on the agenda of ward round discussions. Although in general *Candida* infection is arguably less of a problem in the UK than in the USA,³ for some units it is still likely to be a significant issue, and the report from Belfast by McCrossan *et al* provides some suggestive data on the value of fluconazole prophylaxis targeted at those babies with significant risk factors for fungal infection. In contrast, the paper by Bartels *et al* from Germany is of interest more for generating ideas for future immunological research on the effects of intra-uterine growth restriction on host defences to bacterial infection than for any immediate practical application.

Frustratingly, Bartels *et al* do not inform us as to whether *Candida* infection had any specific relation with growth restriction in their study. There's another subject for future inquiry.

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THE EYE OF FAITH OR COLOUR BLINDNESS?

An article of faith is undermined this month by the finding of O'Donnell *et al* that when we look at newborn babies in the delivery room, we can't tell pink from blue. The investigators used standardised videos rather than live action to undertake this study, but there is no good reason to think that things would be much different in real life. The underlying issue is whether saturation monitors should be more frequently, or even routinely, used during neonatal resuscitation. Ultimately, of course, we need to know whether saturation monitoring in this context makes a difference to outcome, which is quite a different question. After all, the possession of extra information cannot be assumed to translate into better care or improved outcomes: look what happened with pulmonary artery catheters in adult intensive care.

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THE OPERATION WAS A SUCCESS, BUT...

The specialties of paediatric cardiology and cardiac surgery, notwithstanding the Bristol troubles, have seen major developments and successes over the past 25 years. There has been a steady improvement in the outcomes of surgery for congenital heart disease when measured by operative mortality and longer-term survival. But what of morbidities? Apart from the fact that congenital heart disease is often part of a larger picture of anomaly, which will also influence the functional outcome for an infant, the act of undertaking surgery (including surgery at the end of a catheter) can result in varying degrees of damage to the CNS. Miller and McQuillen draw our attention to this in a useful review, raising questions not only about how CNS damage might be reduced, but to my mind, also about the neurodevelopmental component of the follow up of these infants.

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SIZE, SIDS AND FATNESS

That "size matters" is a conclusion of Bartels' paper on infection. It is also the conclusion of Malloy *et al*, looking at its impact on the risk of sudden infant death syndrome (SIDS), but interestingly, they found that smallness for gestational age was more important in relation to other causes of subsequent death than SIDS. Chakraborty *et al*, investigating the issue of "catch-up" growth in relation to childhood obesity, found that obesity at the age of 9 years was much more prevalent in their control group than in their index cases of intrauterine growth restriction. This is reassuring, given the feeding regimes that are widely promoted to help babies make up for growth that has been impaired before birth.

See pages F449, F473 and F479

REFERENCES

- 1 Su B-H, Lin H-C, Chiu H-Y, *et al*. Comparison of ibuprofen and indomethacin for early-targeted treatment of patent ductus arteriosus in extremely premature infants: a randomised controlled trial. *Arch Dis Child Fetal Neonatal Ed* (in press).
- 2 Chorne N, Leonard C, Piecuch R, *et al*. Patent ductus arteriosus and its treatment as risk factors for neonatal and neurodevelopmental morbidity. *Pediatrics* 2007;119:1165-74.
- 3 Clerihew L, Lamagni TL, Brocklehurst P, *et al*. Invasive fungal infection in very low birthweight infants: national prospective surveillance study. *Arch Dis Child Fetal Neonatal Ed* 2006;91:F188-92.



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