therefore any such effect should, for the most part, have been minimised since in this situation compliance is low and the time constant of the respiratory system short.

(3) We have carried out a systematic assessment of the effects of both respiratory rate and inspiratory to expira-
tory ratio on the pattern of interaction between sponta-
neous and mechanical ventilation. Both of these param-
eters can be used to manipulate the infant's pattern of interaction in the vast majority of cases. We did not find the pattern of active expiration against the ventilator inevitably produced a pneumothorax.

References

3 Field D, et al. Calculation of mean airway pressure during neonatal intermittent positive pressure ventilation and high frequency positive pressure ventilation. Pediatric Pulmonology 1985; in press.

Continuous measurement of subarachnoid pressure in the severely asphyxiated newborn

Sirs,

The study by Levene and Evans\(^1\) contains some interesting observations. The underlying supposition is that there is benefit in reducing intracranial pressure (in a way that improves cerebral perfusion pressure) after birth asphyxia. Although this is a plausible notion, I know of no human experimental evidence to support it adequately. I acknowledge that there would be considerable difficulty in obtaining such evidence, which would require a study incorporating more badly asphyxiated babies than most of us will see in a lifetime, but it is surely premature to regard as unethical withholding the treatment which they 'tentatively recommend'. They might argue that mannitol should only be given if intracranial pressure monitoring is performed, and that a procedure as invasive as placing a subdural catheter could not be justified if the information provided was ignored; but in that case how do we proceed? I would be interested to know what experimental approaches to this important issue they think might reasonably be conducted.

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Drs Levene and Evans comment:

We thank Dr Dear for his interest in our paper. Our approach to the problem of postasphyxial cerebral oedema has been to ask three questions:

(1) Does raised intracranial pressure occur after birth asphyxia?
Neonatal auditory brainstem response cannot reliably diagnose brainstem death.
S G Boyd and A Harden

Arch Dis Child 1985 60: 396
doi: 10.1136/adc.60.4.396

Updated information and services can be found at:
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