section and costly (financial and emotional) care of this child could have been avoided.

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1 Taylor WG, Walkinshaw SA, Thomson MA.
Aortic stenosis: reassessment of maternal
2 van der Meek PE, Gerritsen G, Visser GHA.
Fixed fetal heart rate pattern after intrauterine
accidental deceleration. Obstet Gynecol 1985;
3 Nihusie JG, Krust N, Van Wijck J. Fetal brain
death. Two case reports. J Obstet Gynaecol
4 Nihusie JG, Crevels AJ, Van Dongen PWJ. Fetal
brain death: the definition of a fetal heart rate
pattern and its clinical consequences. Obstet

Mr Taylor and Mr Walkinshaw commentary:

We are aware of the case report literature on
fetal brain death, almost all of which is
secondary to known severe hypoxia.1 In our
case we aimed to illustrate cranial nerve
defects, and our dynamic and static ultrasound
findings evolved over several weeks. There was no evidence
from the history or later postmortem exami-
nation to suggest an anoxic insult. The confir-
mation of fetal varicella IgM antibodies was
delayed for several weeks. Local laboratory
testing was negative, but referral to the
Manchester PHSL Reference Laboratory
gave the reported result. The cardiotocograph
(fig 1) does not fulfill all of the criteria for
fetal brain death. The baseline was appro-
priate for the gestation and close scrutiny of the
illustration reveals shallow decelerations.1
We accept, however, that this should have been
elaborated on in our discussion.

Lessons are being learned from anatomical
prenatal diagnosis and false positive diagnoses
illustrate its lack of precision. We would urge
caution in the new field of functional diag-
nosis rather than to take a didactic approach.
We are not aware of any reported literature
on how often a potential false positive diag-
nosis of fetal brain death is made. Even a bi-
ophysical profile score of 2 before delivery is
not always associated with a poor nervous system
outcome.2 We felt after discussion with the
parents that the baby should be given the
benefit of these doubts.

The paediatric management was aggressive
and reflected the reluctance of the paediatrici-
cians to accept the reliability of a functional
diagnosis. The obstetric authors (WGT, SAW)
agree with Sheila Gahagan and Claudine
Amiel-Tison that some of the paediatric inves-
tigation and management was unnecessary.

1 Nihusie JG, Crevels AJ, Van Dongen PWJ. Fetal
brain death: the definition of a fetal heart rate
pattern and its clinical consequences. Obstet
2 Mamin FA, Morrison I, Harman CR, Menticoglou SM. The abnormal

Should we look after babies less than 800 g?

EDITOR.—Dr Robertson writes that "babies
between 500 g and 800 g... clearly have an
excellent chance of neurologically intact
survival" (p 329) and yet provides us with
scant data to support this.1

The results quoted (based on the survival rate
of all babies born in the state of Victoria,
Australia and weighing under 1000 g) show
that there are no survivors under 600 g and a neurologically
intact survival rate of 8% for babies weighing
600-699 g.2 This is a very commendable
achievement but surely not a 'clearly excel-
ent chance'.

Dr Robertson tells us that 'the cost of look-
ing after these babies is not prohibitively, about
$10 000-$15 000 per survivor'. This figure
comes from the estimated cost per survivor of
$13 720 in a trial of 19 babies at the Belfast Royal
Maternity Hospital in 1985-7. The mean
birth weight was 1287 g and the cost per day
in special care $77.4.1 I suggest that the cost of
caring for a 500-800 g baby in 1993 is con-
siderably more than this. (Dr Robertson says
earlier in the article that '8-10 year old data
apply to a standard of neonatal care that is
obsolete' (p 328).) He describes the above
cost as 'phenomenally cheap compared with
... hormone treatment for the menopausal
middle aged' (p 328). The March 1993
edition of the British National Formulary
gives the cost of one year's treatment with
ethinylestradiol as £11.31.

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1 Robertson NRC. Should we look after babies less than
500-999 g at birth. A hospital study. J Pediatr
3 Victoria Infant Collaborative Group. Im-
provement of outcome for infants of birth
weight over 1000 g. Arch Dis Child 1991; 66:
905-9.
4 Tubman TRT, Halliday HL, Norman C. Cost of
surfactant treatment for severe neonatal respira-
tory distress syndrome. A randomised con-
trolled trial, BMJ 1990; 301:842-5.

When will my baby go home?

EDITOR.—Powell et al report that parents of
preterm babies frequently ask: 'when will my
baby go home?' This question is being asked
in the Netherlands as well. In the study cited
by Powell et al as reporting mortality and
morbidity only,2 we asked exactly that
question. The results have been published in
a Dutch language medical journal.3 Of the
nationwide cohort of very preterm (gesta-
tional age less than 32 completed weeks) and
(or) very low birthweight (less than 1500 g)
infants the 992 surviving infants were dis-
charged home after a mean hospital stay of 68
days (range 6-380 days).

For all infants, the difference was calculated
between the expected date of delivery and the
date of discharge. The figure shows the number of infants discharged per category of
days before and after term. The distribution
shows that, as in the study of Powell et al,
many of these infants were discharged around
36 to 37 weeks' postconceptional age (term
minus 25 to minus 15 days). A total of 60% of
all infants went home at or before 42 weeks'
postconceptional age. However, 10% of these
very preterm infants were still in the hospital at
five weeks after the expected date of birth. We
concluded that for this category of preterm
babies, the answer to the parents' question
should be: half of these babies can go home at
or before the expected date of delivery, 70% are
home two weeks after that, and 90% are
home at five weeks after term.

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2 Verloove-Vanhoeck SP, Verwey RA, Brand R, Bennebroek Gravenhorst J, Keirse MJNC,
Ruys JH. Neonatal mortality risk in relation to
gestational age and birthweight. Results of a
randomized trial of preterm and very-low-birth-
weight infants in the Netherlands. Lancet 1986;
3 Pel M, Verloove-Vanhoeck SP. Wanneer gaat een
couveuse-kind naar huis? (When does a special-

Bilateral congenital diaphragmatic hernia — delayed presentation of the contralateral defect

EDITOR.—Approximately 3% of congenital
diaphragmatic defects are bilateral.1 Historically this condition has been almost
uniformly fatal, with the first UK survivor
reported in 1990.2 We have successfully
treated two patients in whom diagnosis of the
contralateral hernia was delayed.
Should we look after babies less than 800g?

N Steel

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Updated information and services can be found at:
http://adc.bmj.com/content/69/5_Spec_No/543.1.citation

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