LETTERS TO THE EDITOR

Surfactant replacement therapy – time for thought

EDITOR,—Professor McClure acknowledges that surfactant treatment benefits most of its recipients but rightly questions whether it should be given to the smallest, sickest babies.¹ Meta-analyses of more than 30 randomised controlled trials enrolling over 6000 preterm babies have shown a consistent reduction in neonatal mortality of about 40% and of pneumothorax of between 40% and 70%.² Many of these trials excluded babies weighing less than 700 or 750 g at birth and some excluded babies with congenital anomalies, low Apgar scores, and severe grades of intraventricular haemorrhage. We agree with Dr Morley who indicates in his commentary that it is only by including extremely small or immature babies in trials that we can learn how (or if) their outcome can be improved. However we would also stress the need at randomisation to document their initial severity of disease, including the degree of hypothermia and asphyxia.

Four trials have looked at the effects of surfactant therapy for babies of <750 g or <27 weeks' gestation; three used prophylactic surfactant³⁻⁵ and one surfactant treatment of established respiratory distress syndrome.⁶ The results are summarised in the table. Prophylactic surfactant reduces the odds of neonatal mortality by about 40%, which is in keeping with the meta-analysis from more mature babies.² The risk of intraventricular haemorrhage is not significantly increased, but there is a trend that needs to be studied further. When Surfactant is used to treat respiratory distress syndrome in babies of 600–700 g there is no clear reduction in neonatal mortality,⁶ which is in keeping with the findings of Kendig *et al.*,⁷ using calf lung surfactant extract, who showed that in babies <26 weeks' gestation survival was better for prophylaxis (64/85 (75%)) than for rescue treatment (39/72 (54%); $p < 0.01$).

As Dr Morley points out in his reply the data are now beginning to support the use of surfactant, preferably by prophylaxis in even the most immature of babies. Some clinicians may accept this evidence and continue to treat these babies while others might call for further and larger randomised controlled

trials, especially if there is a chance that treatment might increase the risk of intraventricular haemorrhage. Also, perhaps one should restate the proved benefits of maternal steroids⁸ and call for their greater use in obstetric practice to limit the need for surfactant therapy.

Another strategy for learning more about the management of extremely immature babies is to undertake systematic audit of their treatment and outcome adjusted for initial clinical and physiological risk. This is being done in over 100 neonatal units in more than 12 countries through the International Neonatal Network. Colleagues who would like more information about this network are invited to contact Dr Tarnow-Mordi in Dundee.

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Putting the clock back 30 years: neonatal care since the 1991 NHS reforms

EDITOR,—In their paper Pope and Wild propose that the 1991 NHS reforms increase the rôle of the district service at the expense of region and that this is undesirable.¹ We would

emphasise that districts have an important contribution to the provision of neonatal services, including the provision of some (1) neonatal intensive care. This leads to:

(1) Fewer transfers to a distant regional unit leading to reduced disruption for the families involved.

(2) Better use of a district's resources. District hospitals need a special care baby nursery: with suitable training existing staff can provide intensive, as well as special care with only a little extra nursing time.

(3) Better resuscitation/stabilisation of babies before transfer. The district neonatal team gain confidence and competence in dealing with babies who need transfer as a result of their greater involvement in intensive care.

(4) Better access to the regional unit. With ever increasing numbers of smaller, iller babies, and with intrinsic limits to the working size of regional units, it is desirable to relieve pressure on regional units by taking on work in districts.

We respond to other points raised:

(1) Monitoring. Audit schemes are developing to ensure adequate checks are made on district units.

(2) Research and training. Junior staff in teaching hospitals should be trained by treating and researching on the most challenging and interesting cases during their stay at the regional centre. All training schemes should involve some rotation out to district units.

(3) The paper emphasises London's unique organisational problems that need tackling politically on a much larger scale.

The NHS reforms have caused us all to look at the organisation of our services; judgments made on a financial basis can be helpful and clarify thinking. The reforms encourage a district as well as a regional view, previously there may have been excessive dependence on the latter.

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C reactive protein and neutrophil band forms in neonates

EDITOR,—The recent paper by Russell *et al* contains some problems that make it difficult to interpret the applicability of the tests described in the detection of neonatal infection.¹

Firstly, the operational diagnostic cut off value for the immature:total neutrophil ratio is given in the abstract as 0.2, and in the text as 0.11. Which one was used?

Secondly, there is something of a self fulfilling prophecy in that two of the indicators examined, namely the neutrophil band count and the C reactive protein concentration, were also able to be used as criteria for initiation of a septic screen. Hence it is difficult to obtain a realistic idea of the usefulness of these tests.

Thirdly, related to the above, how many neutrophil band counts and C reactive protein estimations were performed which did not lead to a septic screen, and of these how

Effect of surfactant therapy on neonatal mortality and intraventricular haemorrhage in babies <750 g or <27 weeks' gestation

	Treated	Control	Odds ratio	95% Confidence intervals
Prophylaxis				
Neonatal mortality				
ALEC ³	13/43	15/32	0.49	0.17 to 1.41
Exosurf ⁴	51/106	60/109	0.76	0.43 to 1.34
Surfactant ⁵	5/26	14/28	0.24	0.06 to 0.93
Typical estimate			0.59	0.37 to 0.93
Intraventricular haemorrhage				
ALEC ³	14/42	10/31	1.05	0.35 to 3.17
Exosurf ⁴	45/106	39/109	1.32	0.74 to 2.38
Surfactant ⁵	7/26	7/28	1.11	0.28 to 4.40
Typical estimate			1.23	0.77 to 1.98
Treatment				
Neonatal mortality				
Surfactant ⁶	35/81	36/76	0.85	0.43 to 1.67