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

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Mr Taylor and Mr Walkinshaw comment:

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 ultrasound findings evolved over several weeks. There was no evidence from the history or later postmortem examination to suggest an anoxic insult. The confirmation 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 cardiocotograph (our fig 1) does not fulfil all of the criteria for fetal brain death. The baseline was appropriate 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 diagnosis rather than to take a didactic approach.

We are not aware of any reported literature on how often a potential false positive diagnosis of fetal brain death is made. Even a biophysical profile score of 2 before delivery is not always associated with a poor neonatal 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 paediatricians 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 investigations and management was unnecessary.

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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 no survivors under 600 g and a neurologically intact survival rate of 8% for babies weighing 600-699 g.^{2,3} This is a very commendable achievement but surely not 'clearly an excellent chance'.

Dr Robertson tells us that 'the cost of looking after these babies is not prohibitive, 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 in Belfast Royal Maternity Hospital in 1985-7. The mean birth weight was 1287 g and the cost per day in special care £77.⁴ I suggest that the cost of caring for a 500-800 g baby in 1993 is considerably 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 327)). 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 ethinyloestradiol as £11.31.

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When will my baby go home?

EDITOR,—Powell *et al* report that parents of preterm babies frequently ask: 'when will my baby go home?'.¹ 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 (gestational age less than 32 completed weeks) and (or) very low birthweight (less than 1500 g) infants the 992 surviving infants were discharged 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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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.

Number of infants discharged at various ages in relation to term date (expected date of delivery) (n=992). (Figure adapted from *Het Nederlands Tijdschrift voor Geneeskunde* (1988; 132: 1687-8³) and reproduced with permission.)