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‘...officiously to keep alive’

Sir,

May I congratulate Dr Walker and Professor Campbell on their excellent contributions, with most of which I wholeheartedly agree.1 2 I would, however, like to comment on two things said by Professor Campbell. Firstly, his attitude towards the abortus that refuses to die. I am unhappy with a blanket statement that we should resist all pressures to resuscitate such neonates. Each case must be assessed on its merits. The fact that the parents do not want the baby is irrelevant. I have certainly been involved in cases where a genuine error of gestational age assessment has been made with the result that a near 1000 g baby has been produced. The odds are in favour of such a baby being normal and adoptable, and we should not deny him that chance.

Furthermore, if an obstetrician is man enough to admit a mistake and ask a neonatologist’s help, we should give it, and I believe that that means providing all the components of standard neonatal care. If the neonate is ‘fetal’, and weighs a lot less than any previous survivor in that neonatal unit, then of course it is correct not to resuscitate it, but it should be admitted to the neonatal unit, and kept warm and comfortable. Apart from anything else, this is the only way both members of the perinatal team can be protected from the unpleasant activities of what Dr Walker neatly calls ‘clandestine groups’.

Secondly, and much more important, I am perpetually irritated by people who say we have to practice within economic constraints. Who says we have to? For the money required to establish satisfactory standards in neonatal care resources are not limited in real terms, only by dint of government control. The United Kingdom spends a ludicrously small 5-8-6-0% of its national product on health care,3 and an increase of 2% to bring us in line with say Switzerland or Australia (and incidentally still well below Sweden and France) would give us at least an extra 5 billion pounds to spend. Neonatal paediatricians would settle for a mere 1% of this, which is well above that which was asked for after the Short report.4 When and if we have spent all this, opinion polls show that the electorate are prepared for extra taxation to cover health care.5 Only when this option is exhausted, if indeed it ever can be exhausted, should we begin to admit that resources are limited. Until then paediatricians should continue to make clear and well documented demands for more funds to provide an acceptable standard of care for our patients, and stop creeping around toeing the party line.

References

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Intestinal permeability tests and integrity of the small intestinal mucosa

Sir,

We read with interest the article by Nathavitharana et al.1 These workers have studied lactulose and mannitol intestinal permeability in 43 children with various degrees of intestinal mucosal damage, and compared the results with a control group of 53 children with histologically normal jejunai biopsy specimens. They showed that urinary mannitol:lactulose ratio was a sensitive test only for the detection of severe villous atrophy. Lesser degrees of mucosal damage could not be detected by this test.

We have developed and validated a sugar solution test in normal children and then used it to determine gut damage from chemotherapy in children with cancer. The sugar solution contains lactulose 5 g, mannitol 5 g, and 3-0-methyl-D-glucose 2 g, made up to 100 ml with water, which gives a measured osmolality of 696 mmol/kg. The dose given is 80 ml/m². The addition of 3-0-methyl-D-glucose to the standard intestinal permeability test also allows the measurement of active transport and may increase the sensitivity of the test in the detection of mucosal abnormalities. We have recently reported the preliminary results, which showed the test allows quantification of severity and timing of gut damage after chemotherapy.2 The sugars are accurately assayed by gas-liquid chromatography, the test is easy to perform and was well tolerated by normal children and children with cancer.

The osmolality of the test solution used by Nathavitharana and colleagues was 274 mmol/kg and differs from ours.

The Birmingham group recognised that the use of a more hypertonic solution might have improved the discrimination between damaged and normal mucosa.3 They suggested, however, that there was potential risk of inducing osmotic diarrhoea associated with the ingestion of hyperosmolar solutions in children. Our study has shown that children can tolerate relatively hyperosmolar oral solutions. Out of 49 normal children who performed the test, mild nausea was observed in two occasions and the passage of one loose stool was reported in two children.


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