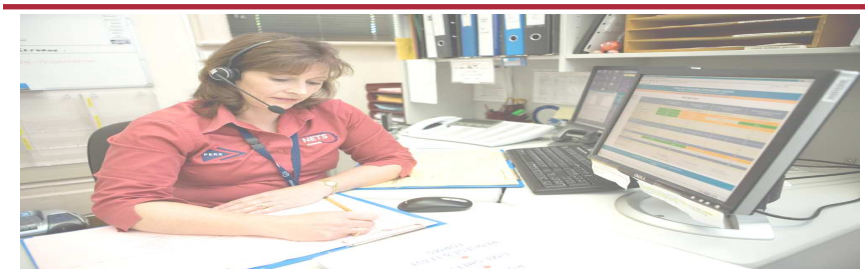
Newsletter

July 2007



THIS ISSUE:

Care at the borderlines of viability

fFN update

Request for feedback

Perinatal Care at the borderlines of viability

In this issue, I have provided links to three short articles discussing the appropriate approach to neonatal resuscitation (and therefore by implication maternal transfer) in the 'grey area' at the borderlines of viability, which appears to span the gestations between 23+0 and 25+6 weeks. These births represent around 1% of all deliveries, and 14% of PERS referrals (Nov 05 - June 2007). Please click on the article to open it.

This issue is being discussed at NSAC, so it may be helpful if any of you have any feedback to direct it to Dr. John Mills at RCH john.mills@rch.org.au who is looking into the possibility of developing a consensus statement..

ARTICLE ONE

Published late last year in the MJA, this article outlines the NSW consensus position. My understanding is that prior to 23+0 weeks, initiation of resuscitation is not appropriate, and up to 24 weeks would be considered but generally discouraged. Between 23+0 and 25+6 there is 'an increasing obligation to treat', but the parent's input regarding resuscitation or not (in the context of them having received accurate information regarding likely neonatal outcomes) should be respected. In an otherwise normal infant born after 26 weeks, the obligation to treat is very high.

CONSENSUS STATEMENT

Perinatal care at the borderlines of viability: a consensus statement based on a NSW and ACT consensus workshop

ARTICLE TWO

A summary of the Nuffield Council on Bioethics report on *Critical care decisions in fetal and neonatal medicine*, this includes a very informative chart showing the outcomes at different gestations. For example, at 22-23 weeks, only 1% of babies will survive to hospital discharge, and all the survivors have a disability. Between 25-26 weeks, 44% will survive to hospital discharge and of the long term survivors: 24% have no disability at all, 35% have a mild disability but the remaining 40% are significantly disabled.

Critical care decisions in fetal and neonatal medicine: ethical issues

a guide to the Report

Introduction

NUFFIELD COUNCIL ON BIOETHICS

ARTICLE THREE

A brief comment published in the BMJ recently, which suggests guidance that can be offered to parents and clinicians: *22-23 weeks,* generally do not give intensive care. At *23-24 weeks,* recognise that although 11% may survive, around two-thirds will have major disabilities, so the parents should receive careful counseling to assist in their decision-making. At *24-25 weeks,* as 26% are likely to survive, consider the specific clinical picture and reach a consensus with the parents regarding care. *Over 25 weeks,* intensive care should normally be given.

News

Ethics group rules on treating premature babies

REQUEST FOR FEEDBACK

Thankyou to the PERS Obstetricians who have provided feedback on the Time Critical Process and/or the proposed Orientation package as outlined in the May 2007 Newsletter. Please continue to provide feedback to kate.freeman@rwh.org.au or jacqui.smith@rwh.org.au

FETAL FIBRONECTIN UPDATE

Andrea Moore, PERS Clinical Coordinator and Project Manager of the recent state wide implementation of fFN testing, is compiling a report on a review that has been undertaken on the implementation. This will be included in the next Newsletter. Please follow this link to a brief article, which gives a fairly balanced and accessible perspective on the usefulness of fFN testing in women presenting with apparent preterm labour.

GREEN OFFICE UPDATE

Some of the staff at PERS and NETS have been making a personal commitment to reducing their impact on the environment by joining Green*fleet* in order to offset the greenhouse gas emissions of their vehicles.

Go to www.greenfleet.com.au/ to calculate your greenhouse gas emissions and to offset your own vehicle's emissions for a tax deductible annual fee of $40.

Victorian Perinatal Emergency Referral Service