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## PEDIATRICS, NEONATOLOGY &amp; PRIMARY CARE

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**The baby under 500 grams****Richard Mupanemunda**

University Hospitals Birmingham, UK

The last 25 years have witnessed continued improvement in the survival of extremely low birth weight infants particularly in the industrialized nations of the world. This has been accompanied by a shift in attitudes to the provision of intensive care to infants regarded as being at the margins of viability. Intensive care is increasingly offered to such infants with significant intra- and inter-country variations in outcomes. Infants of birth weight <500 g encapsulate the moral and ethical dilemmas of perinatal clinicians who struggle to balance the natural parental emotional desire for every effort to be made to save their premature infants with the clinicians' uncertainty about the infant's prospects for survival and/or disability. It is difficult for perinatal staff to predict the medical prognosis for extremely preterm infants which means some viable infants might die if not offered aggressive treatment. Detailed outcome data for this group of infants is still limited but reported survival rates vary from 11% to 68% though concerns remain regarding long term morbidity. Common morbidities included bronchopulmonary dysplasia BPD, Retinopathy of Prematurity (ROP), Intraventricular Haemorrhage (IVH), Necrotizing Enterocolitis (NEC) and cerebral palsy. Survival rates increase with increasing birth weight and gestational age, is more likely for small for gestational age than appropriate for gestational age infants, is greater for female infants and singletons. Despite the increased mortality and morbidity, up to a third of survivors have been reported free from handicap at age of two years. Current evidence suggests that a proactive and positive approach to intervention in maternal and newborn care including obstetric interventions, antenatal steroids, tocolysis and caesarian delivery with a neonatologist present at birth, for 'a trial of life' including intubation and surfactant administration may increase survival without increasing neurological impairment. Providing perinatal teams with up-to-date outcome data on this group of infants may help further shift attitudes towards a more active and optimistic approach which may encourage higher expectations of a favorable outcome among obstetricians and neonatologists. The Japanese experience clearly supports this view as attested by the amendment of their viability limit from 24 to 22 completed weeks of gestation.

**Biography**

Richard Mupanemunda has completed his Medical studies graduation from University of Southampton. He teaches Pediatrics and Neonatal Medicine at University Hospitals Birmingham NHS Foundation Trust. His interests include the use of inhaled nitric oxide in the treatment of hypoxic respiratory failure in newborns, airway management and the ethics of healthcare provision.