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ORIGINAL ARTICLE

Opinions of Brazilian resuscitation instructors regarding resuscitation in the delivery room of extremely preterm newborns☆,☆☆

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Abstract

Objective: To describe the opinions of pediatricians who teach resuscitation in Brazil on initiating and limiting the delivery room resuscitation of extremely preterm infants.

Method: Cross-sectional study with electronic questionnaire (Dec/2011–Sep/2013) sent to pediatricians who are instructors of the Neonatal Resuscitation Program of the Brazilian Society of Pediatrics, containing three hypothetical clinical cases: (1) decision to start the delivery room resuscitation; (2) limitation of neonatal intensive care after delivery room resuscitation; (3) limitation of advanced resuscitation in the delivery room. For each case, it was requested that the instructor indicate the best management for each gestational age between 23 and 26 weeks. A descriptive analysis was performed.

Results: 560 (82%) instructors agreed to participate. Only 9% of the instructors reported the existence of written guidelines at their hospital regarding limitations of delivery room resuscitation. At 23 weeks, 50% of the instructors would initiate delivery room resuscitation procedures. At 26 weeks, 2% would decide based on birth weight and/or presence of fused eyelids. Among the participants, 38% would re-evaluate their delivery room decision and limit the care for 23-week neonates in the neonatal intensive care unit. As for advanced resuscitation, 45% and 4% of the respondents, at 23 and 26 weeks, respectively, would not apply chest compressions and/or medications.

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Conclusion: Difficulty can be observed regarding the decision to not resuscitate a preterm infant with 23 weeks of gestational age. At the same time, a small percentage of pediatricians would not resuscitate neonates of unquestionable viability at 26 weeks of gestational age in the delivery room.

PALAVRAS-CHAVE
Recém-nascido;
Bioética;
Ordens quanto à Conduta (Ética Médica);
Ressuscitação Cardiopulmonar;
Viabilidade Fetal

Opiniões dos instrutores de reanimação brasileiros quanto à reanimação em sala de parto de em recém-nascidos pré-termo extremos

Resumo
Objetivo: Descrever opiniões dos pediatras que ensinam reanimação no Brasil a respeito de iniciar e limitar a reanimação em sala de parto de neonatos pré-termo extremos.
Método: Estudo transversal com questionário eletrônico (Dez/11-Set/13) enviado aos instrutores do Programa de Reanimação Neonatal da Sociedade Brasileira de Pediatria contendo três casos clínicos hipotéticos: 1) decisão de iniciar ou não a reanimação; 2) limitação ou não dos cuidados intensivos após a reanimação em sala de parto; 3) limitação ou não da reanimação avançada em sala de parto. Para cada caso foi solicitada a indicação da conduta para cada idade gestacional entre 23-26 semanas. A análise foi descritiva por meio da frequência das respostas.
Resultados: 560 (82%) instrutores consentiram em participar. Apenas 9% instrutores afirmaram existir em seu hospital norma escrita sobre quando não iniciar a reanimação em sala de parto. Com 23 semanas, 50% dos instrutores fariam a reanimação em sala de parto e, com 26 semanas, 2% baseariam sua decisão no peso ao nascer e/ou na abertura da fenda palpebral. Dos entrevistados, 38% reavaliariam sua decisão e limitariam o cuidado na UTI a medidas de conforto para nascidos de 23 semanas reanimados na sala de parto. Quanto aos procedimentos de reanimação avançada, 45% e 4% com 23 e 26 semanas, respectivamente, não indicariam tais manobras.
Conclusão: Observa-se dificuldade na opção de não reanimar neonatos com 23 semanas de gestação e, ao mesmo tempo, um pequeno percentual de pediatras não reanima, na sala de parto, neonatos cuja viabilidade não é questionada (26 semanas).

Introduction

Available data indicate that infants at less than 23 weeks of gestational age are too immature to survive with the current technology; on the other hand, those born at 25 weeks or more have significant survival rates and a large proportion of them survive without severe sequelae.[1–4] Thus, using as guide the survival rates of preterm neonates, the literature, in general, has established as the limit of viability the period between 22 and 25 weeks of gestational age (GA), below which the degree of biological immaturity is a limiting factor to life and above which the benefit of treatment is not challenged.[5,6]

However, there is great difficulty in defining the proper management for fetuses born between these limits. During this period, the uncertainty of the result is the rule, rather than the exception, and is therefore referred to as the ''gray area,'' because survival and prognosis are uncertain, and there is doubt about the best approach to be used and the degree of investment and intervention to be made, since the data available for decision-making are limited, and although they help, they do not overrule the uncertainty or the possibility of error. For the group of infants born in the gray area, two courses of action are possible: (1) restriction of life support measures and the possibility of death as outcome, or increase in sequelae if the patient does not die; or (2) access to all available technology, having as possible outcomes death with pain and suffering, or the possibility of survival with high rates of major sequelae, or the chance of a good clinical evolution, with survival without sequelae or with minor sequelae.[5,7–10]

Therefore, considering the multiple uncertainties, the Neonatal Resuscitation Program of the Brazilian Society of Pediatrics (Programa de Reanimação Neonatal da Sociedade Brasileira de Pediatria [PRN-SBP]) recommends caution and, considering the additional information obtained after the birth, the decision not to resuscitate may be made by the medical team in the delivery room or, if doubts remain, the team must resuscitate the patient, take him to the NICU, and then gather the necessary information, including the family's wishes, in order to eventually limit the life support measures.

In this context, it is essential to know what Brazilian physicians think about the role of parents in decision-making about the type of intervention they want for their children, such as how the decisions are made about the resuscitation of an extremely preterm neonate and how the possible sequelae of these fetuses are addressed with parents; *i.e.*,