

In our study we excluded large masses and subglottic lesions, due to the risk of inflammatory reaction or haemorrhage that could produce airway compromise. The trachea was intubated in all of our patients. No exclusions were applied by Ah-See *et al.* and only 15 of their patients required intubation reflecting their practice of jet ventilation. However, we also considered the clinical criteria the most reliable method of discharge assessment. We performed an oropharynx direct visualization and an indirect laryngoscopy or fibroscopy before discharge.

Although 80 per cent of the patients studied by Ah-See *et al.* were suitable for discharge home regardless of the ASA score, 11 of the 13 patients (85 per cent) that required reintubation in the Hill *et al.* (1987) series had underlying chronic obstructive pulmonary disease. The only patient we had to admit overnight also had chronic obstructive pulmonary disease. Eight of nine patients admitted after laryngoscopy had abnormal airways pre-operatively in a recent report by Armstrong *et al.* (1997). These results suggest that a large number of cases should be studied before considering patients in physical status III (non-incapacitating severe systemic disease) or IV (incapacitating systemic disease) of the ASA classification as appropriate candidates.

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European Consensus Statement on Neonatal Hearing Screening

Dear Sir,

I wish to inform you of the final consensus produced at the European Consensus Development Conference on Neonatal Hearing Screening, 15–16 May, 1998.

1. Permanent childhood hearing impairment¹ (PCHI) is a serious public health problem affecting at least one baby in 1,000. Intervention is considered to be most successful if commenced

in the first few months of life. Therefore, identification by screening at or shortly after birth has the potential to improve quality of life and opportunities for those affected.

2. Effective programmes of intervention are well established.
3. Methods for identification of PCHI in the neonatal stage are now accepted clinical practice. They are effective and can be expected to identify at least 80 per cent of cases of PCHI whilst incorrectly failing two to three per cent of normally hearing babies in well-controlled programmes.
4. Neonatal testing in maternity hospitals is more effective and less expensive than behavioural screening conventionally carried out at seven to nine months.
5. Targeting neonatal testing on only the six to eight per cent of babies at increased risk² of PCHI reduces costs but cannot identify more than 40–50 per cent of cases. Targeted neonatal hearing screening in parallel with seven to nine month behavioural testing is more expensive and less effective than universal neonatal screening.
6. Hearing screening in the neonatal period cannot identify acquired or progressive hearing loss occurring subsequently. Surveillance methods are required to identify those cases, which may be 10–20 per cent of all permanent childhood hearing impairment.
7. Risks associated with neonatal hearing screening include anxiety from false positive results and possible delayed diagnosis from false negative results, but these risks are acceptable in view of the expected benefits.
8. Neonatal hearing screening should be considered to be the first part of a programme of habilitation of hearing impaired children, including facilities for diagnosis and assessment.
9. A system of quality control is an essential component of a neonatal hearing screening programme. Quality control includes training of personnel and audit of performance. The person responsible for quality control should be identified.
10. Although the healthcare systems in Europe differ from country to country in terms of organization and funding, implementation of neonatal hearing screening programmes should not be delayed. This will give new European citizens greater opportunities and better quality of life into the next millennium.

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¹Defined here as a bilateral permanent hearing impairment greater than or equal to 40 dB averaged over the frequencies 0.5, 1, 2 and 4 kHz.

²Examples include neonatal intensive care and family history of hearing impairment.