Association/American Academy of Pediatrics (AHA/AAP) in their new guidelines both advocate the use of 100% O2 for newborn resuscitation. The International Guidelines 2000 state: "100% oxygen has been used traditionally for rapid reversal of hypoxia. Although biochemical and preliminary clinical evidence suggest that lower inspired oxygen concentrations may be useful in some settings, data is insufficient to justify a change from the recommendation that 100% oxygen be used if assisted ventilation is required. If supplemental oxygen is unavailable and positive ventilation is required, use room air". The oxygen source is recommended to be at least 5 L/ min, and the oxygen should be held close to the face to maximize the inhaled concentration. And it is underlined that self-inflating bags often will not passively deliver sufficient oxygen flow. Free flow oxygen could be delivered through a facemask and a flowinflating bag, an oxygen mask, or a hand cupped around oxygen tubing. The goal of supplemental oxygen administration should be normoxia. The major change of the points dealing with oxygen since the 1992 recommendations is that the new guidelines explicitly state that room air should be used if oxygen is not available. This is an important statement since in some places resuscitation seems occassionally not to be initiated at all if supplemental oxygen is not present. Furthermore, the sentences in the 1992 AHA recommendations indicating that brief exposure to hyperoxia during resuscitation is not harmful, have been removed.

L110

NEONATAL ETHICAL PROBLEMS IN DEVELOPED AND DEVELOPING COUNTRIES

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Among the many neonatal ethical problems, the one which neonatologists are faced with on a regular basis involves the issue of selective non-treatment, that is, clinical decisions made after the birth of a liveborn infant to either withhold or withdraw treatment in certain clinical situations. If doctors believe that the infant has little prospect for intact survival, their management would be suboptimal and they create a self-fulfilling prophecy. A policy establishing criteria for initiating life-sustaining treatment must be developed with proper consideration of the cultural, social and economic factors operating in the developed or developing country. There are infants whose subsequent clinical course after initiation of neonatal intensive care will indicate that further curative efforts are futile or lack compensating benefit. A policy establishing criteria for withdrawing life-sustaining treatment must also be developed, to allow the appropriate use of palliative care in these instances. The clinical situations in which selective non-treatment is taking place in the neonatal intensive care unit are: (1) when death is considered to be inevitable whatever treatment is provided, (2) even when death is not inevitable, there is a significantly high risk of severe physical and mental disability should the infant survive, and (3) when survival with moderate disability is possible, but the infant is likely to experience ongoing pain and suffering, repeated hospitalisation and invasive treatment, and early death in childhood. The principles underlining clinical practice should be the same for developed and developing countries, but there must be less medical paternalism and more informed parental involvement in developing countries. Compared to developed countries, communications between the medical and nursing staff and the parents are less adequate in developing countries.

L111

NEONATAL INTENSIVE CARE NURSING

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Even the specially formed NICUs improve the prognosis of the prematüre and diseased newborns,they are foreign environments that are full of stimulators for the prematüre and diased newborns that have been seperated their physiological environments earlier. Tecnological instruments and interventions performed in this environment make the adaptation eforts of the infant to his/her new life hard, and dar-

ken his/her life with chaos and suffer. The long –term effects of such situation cause the infant to appear motor,sensorial and other developmental problems. "Individualized Developmental Care" which involves communication with the infant,assesment of the infant and plannig the care of the infant forms the key of the success in NICU.The approach of Individualized Developmental Care needs the continual and harmonious working of not only the nurses but also all the members of the medical team. Our basic goal in NICU is to provide the behavioral and developmental organization of newborn and gradually make the care given less required,and to transfer such task to the owners having the rigts mostly that is to say to the parents.

L113

MATERNAL MORTALITY IN MULTIPLE PREGNANCY

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The combination of physiological changes and perinatal pathologies certainly increase the maternal risk for serious morbidity associated with multiple pregnancies. A recent review cited mortality cases attributed to beta-mimetic tocolysis, 1:6 deaths from eclampsia, and delivery-related mortality attributed to blood loss.

In France, the maternal mortality was 10.2 vs. 4.4. per 100,000 live birth in multiples vs. singletons, and for the entire Europe, the corresponding figures were 14.9 vs. 5.2.

In a database from Latin America the adjusted relative risks for pre-eclamptic toxemia, eclampsia, preterm labor, anemia, post-partum hemorrhage, and endometritis were 2.2, 3, 3.9, 1.8, 2, and 1.8, respectively. These risks were mainly associated with nulliparity, but the risk of death for the multipara was twice in a multiple pregnancy than in a singleton gestation.

Admittedly, the true incidence of maternal mortality in multiple pregnancies is unknown, merely because death is registered by the prime cause (e.g., eclampsia) but not attributed to what increased the risk for eclampsia (i.e., a twin pregnancy). With the increasing numbers of multiple births, it is important to register all mortalities by plurality in order to realize the risk of maternal death in multiple pregnancies.

L115

MATERNAL MORTALITY IN TURKEY

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All maternal deaths are considered as a social injustice. For this reason, governments should take necessary measures to make motherhood safer. In order to prevent premature deaths of women, causes of deaths must be known. In Turkey, the latest survey conducted in hospitals in selected 53 provinces. This hospital-based survey revealed that maternal mortalities make up 5% of all women deaths and maternal mortality is 49.2 per hundred thousand live births. Factors which are related with the status of women including, education, socio-economic conditions, early marriage age, and fertility level have influence maternal mortality level in the community. Accessibility and availability of maternal health care services are also very important factor to reduce maternal mortality.