

## EDITORIALS



## Clinical Decisions

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In this issue of the *Journal*, we begin an experiment in understanding the therapeutic decisions that physicians make every day at the bedside and in the office. At the foundation of the experiment is new scientific information (in this case, Original Articles by the American Lung Association Asthma Clinical Research Centers<sup>1</sup> and by Papi et al.<sup>2</sup> on the treatment of mild asthma) that we believe has implications for the practice of medicine. In the past, we would have solicited an editorial to evaluate the studies and discuss whether the data presented should change practice. With the availability of interactive communication over the Internet, however, we can now ask our readers what they would do in a given clinical setting and why. The result is a new feature called Clinical Decisions.

To frame the therapeutic question, we developed a fictitious case vignette and three management options, any of which could be considered correct. We then recruited three experts, each assigned to make a case in support of one of the management options. This is where the reader comes in. On our Web site, [www.nejm.org](http://www.nejm.org), there is a forum in which readers can vote for one of the management options and, if they wish, add brief comments explaining that choice. (At this time, the feature is open to all readers who undergo a simple registration online, regardless of

whether they are *Journal* subscribers.) Readers can base their choice on previous experience, previously published literature, published guidelines, and the two relevant Original Articles in this issue of the *Journal*. To the extent possible, we will post these comments at [www.nejm.org](http://www.nejm.org), where we will also post the results of the polling as they are available. Polling will continue until 4 weeks after publication of this issue. The results should represent the community's consensus on this issue.

We realize that by writing the case vignette and outlining the management options, we are limiting the options of both our expert commentators and our readers. But only by focusing the question can we expect a clear answer to emerge. We consider Clinical Decisions to be an experiment. If it is successful, the debate will be lively and the polling will be robust and reflective of the community's opinions. We look forward to learning how you, through the online Clinical Decisions Forum, would manage this challenging case.

1. The American Lung Association Asthma Clinical Research Centers. Randomized comparison of strategies for reducing treatment in mild persistent asthma. *N Engl J Med* 2007;356:2027-39.

2. Papi A, Canonica GW, Maestrelli P, et al. Rescue use of inhaled beclomethasone and albuterol in a single inhaler for mild asthma. *N Engl J Med* 2007;356:2040-52.

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## Prematurity and the Legacy of Intrauterine Stress

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In 1960, a neonate weighing 1000 g had a 95% risk of death; today, a neonate with the same birth weight has a 95% chance of surviving. This progress in neonatology,<sup>1</sup> including the advent and evolution of neonatal intensive care units (NICUs)

and procedures that save premature infants, has led to markedly improved survival both for infants with very low birth weight (<1500 g) and for those with extremely low birth weight (<1000 g).

What happens to these babies when they grow