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LETTER TO THE EDITOR

From publication to action for early detection, surveillance and intervention in cerebral palsy in Spain—Who, how and now

De la publicación a la acción para la detección, seguimiento e intervención temprana en parálisis cerebral en España: quién, cómo y ahora

To the Editor:

We write in response to the article published in *ANALES DE PEDIATRÍA* titled ''Motor, cognitive and behavioural outcomes after neonatal hypoxic-ischaemic encephalopathy''.[1] We believe that the work carried out by Montesclaros Hortigüela and members of the ARAHIP Group (Programme for the Integrated Care of Newborns with Perinatal Hypoxic-Ischaemic Insult) in the follow-up of children with hypoxic-ischemic encephalopathy underscores the pressing need to implement the international guidelines for early detection and intervention in cerebral palsy (CP)[2] in Spain.

Hypoxic-ischemic encephalopathy and prematurity, both risk factors that can be identified from birth, are ''red flags'' that call for follow-up and referral. One example of a possible response is the protocol established by the Sociedad Española de Neonatología (Spanish Society of Neonatology) for infants born before 32 weeks' gestation or with birth weights less than 1500 g, which includes recommendations such as the use of the Prechtl General Movements Assessment (GMA) or the Hammersmith Infant Neurological Examination (HINE).

In this regard, ''who'' is eligible for receiving care based on current guidelines is the first aspect requiring critical analysis. While the standardized follow-up of newborns at risk—including, among others, moderately and late preterm newborns—has yet to be fully established, it may still not be sufficient. In 40% of children with CP, the pregnancy and labor are uneventful,[2] increasing the probability of a ''watchful waiting'' approach, a situation that is frequently associated with delays in follow-up, referral and diagnosis. This evinces the need to implement specific and evidence-based strategies in seemingly ''low-risk''—not requiring neonatal intensive care—term newborns, honing the traditional armamentarium of pediatric neurologic follow-up: changes in tone and spasticity, reflexes and reactions and motor delay.

The identification of risk factors in the context of routine prenatal care (e.g., preeclampsia, chorioamnionitis, tobacco or other substance use), at childbirth (e.g., 5-min Apgar < 6) or in the child (e.g., male sex, birth weight) could substantially improve the routine screening of CP in pediatrics.[3] Similarly, the family plays a relevant role in the identification of atypical behaviors or symptoms that could constitute warning signs, allowing for early monitoring.

The issue of ''how'' to improve practices for early detection of CP brings our attention to the 17-year gap that exists between the publication of clinical practice guidelines and actual changes in real-world clinical practice.[4] Thus, a collective effort must be exerted, driven by current knowledge and international experiences,[5] to promote and consolidate the implementation of early detection programs in Spain. This will require the previous analysis and addressing of barriers such as the lack of familiarity of clinicians with the Prechtl GMA and the HINE—moving towards their inclusion in a standardized universal pediatric screening protocol, similar in nature to the hearing screening program—inconsistent or unclear referral pathways, or long waitlists in the context of a manifest inequality between regions.

''Now'' is the time to act. By implementing international recommendations in a coordinated and effective manner—leaving no one behind—we can promote the optimization of neuroplasticity during a critical window of development, intervene early on functional impairment and any concurrent conditions in the child—pain, hip dysplasia, epilepsy, visual or hearing impairment—and adopt strategies to improve the psychosocial wellbeing of families. Seventeen years is too long a time. Now we can close the gap.

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