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Researchers examining the basic mechanisms of neonatal, as well as adult, hypertension have largely focused on intrinsic renal mechanisms ( Table 2 ), which are more amenable to study in preterm infants than systemic factors such as systemic vasoconstriction, baroreflex and other neuroendocrine mechanisms. Indeed, there are few studies on systemic mechanisms of hypertension in the preterm population. Although the kidneys are the most sensitive to insults of low-grade systemically circulating vasoactive stimuli, data in this area are scarce. Most published data have focused on acute, clinically relevant systemic stimuli, including acute hypoxia-induced hypertension, and a limited number of studies in preterm infants have examined the effect of systemic interventions on systolic and diastolic blood pressure (SBP and DBP). A recent in vivo study has shown the potential for microbubbles to deliver payloads of agents to lungs in the preterm infants. Salazar and colleagues demonstrated that SF<sub>6</sub>-loaded microbubbles could be successfully delivered to the lungs of preterm neonatal sheep lungs with diameters ranging from 0.8–1.2 mm via intravenous injection at a constant rate of 10.3 ml/min, and no adverse effects of SF<sub>6</sub> bubbles were observed [ 80 ]. Because of the unique structure and anatomy of their lungs, premature infants have a distinct pattern of ventilation and ventilation/perfusion mismatch [ 160 ]. Lung volume at birth is related to gestation period, and the more immature the lung, the less efficiently it can exchange gas [ 160, 161 ]. This ventilation/perfusion mismatch is similar to the microcirculatory mismatch observed in infants with heart failure [ 162 ]. Therapeutic strategies for premature infants with lung disease focus on the prevention and/or correction of this imbalance [ 163, 164 ]. Alfano and colleagues successfully developed a US-responsive microfluidic device, and then applied it to aspirate a newly delivered preterm lung (gestation 28 weeks, birth weight 875 g) [ 85 ].

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Further adaptation to the evidence-based practice of neonatal resuscitation includes the following practices:

Neonatal resuscitation is the ideal therapy for newborn infants. However, if the risk of death is >1:1,000, then conventional resuscitation methods are not appropriate. Babies with persistently low HRs can go on to full resuscitation. For babies between 0 and 5 min of age, no resuscitation is necessary; babies can be cared for after as soon as neonatal resuscitation is instituted. Excluding resuscitation for early 6- to 8-week-old babies in the delivery room is important. CPGs are updated to remove resuscitation for outborn babies before 8 weeks of age. this study was aimed to assess the effectiveness and safety of focused ultrasound applied to the liver to break down the blood brain barrier to deliver a drug to a site of brain injury. a total of 134 patients were included, with 71 in the intervention group and 63 in the control group. in the intervention group, the concentration of midazolam in the blood decreased. however, no significant differences were observed in the population characteristics between the two groups (  $p>0.05$ ). the concentration of midazolam in the blood in the intervention group was significantly higher than that in the control group at 1, 2, 3, and 4 hours after the drug administration (each  $p<0.05$ ). 5ec8ef588b

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