LETTERS TO THE EDITOR

Randomised trial of early tapping in neonatal post haemorrhagic ventricular dilatation: results at 30 months

EDITOR,—In reporting the results of follow up from questionnaires to the clinicians involved in the care of children randomised after the official end of this multicentre trial, Johnson et al have highlighted an important issue.1 Major functional loss can be identified at the age of 30 months by questionnaire, particularly when there is an unbiased comparison group. The principal question in this work was whether early tapping carried an advantage over conservative treatment in the prevention of major functional loss detectable at the age of 2 years. What may be missed, however, are impairments which, at that age, are not perceived as major deviations from the norm. Abnormalities and asymmetries of tone may escape notice in a routine examination and become obvious only at a later stage. It is therefore not surprising that there are large differences between the proportions of children reported as being ‘normal’ and those having neuromotor impairment without functional loss, in children randomised before January 1987 compared with those randomised after this date.

There may also be difficulties in categorising children as multiply or singly impaired without more formal testing. Silence or poor expressive language at this age is attributed to shyness — particularly in the unfamiliar context of a short clinic visit.

However, for secondary questions concerning the role of ascertainment methods it is important to understand what may be occurring in the brains of those measured as not impaired. Johnson et al have highlighted an important issue.1 Further investigation by the paediatrician at the time of a routine hospital check up is likely to prompt a more detailed and structured assessment. Additional questions, which cannot normally be answered retrospectively from the questionnaire, may also be included. For instance, in the questionnaire used in the follow up of babies entered into a multicentre trial of the use of acetazolamide and frusmid in post-haemorrhagic ventricular dilatation, reference was made about limb and axial tone and reflex changes. This is completed by the paediatrician at the time of an outpatient clinic visit.

The trial design is for secondary questions to be addressed. It is important that those addressing these questions are able to assess the advantages and disadvantages of questionnaires completed by paediatricians in clinics, health visitors, GPs and parents (and teachers for school age children).

Pro- or antioxidant activity of vitamin C in preterm infants

EDITOR,—It is with great interest that we read the paper by Silvers et al describing plasma ascorbic acid concentrations and plasma antioxidant activity in premature infants at birth, and potential implications for reactive oxygen species induced injury. The antioxidant activity of plasma was tested by measuring the ability of plasma to scavenge the lipid peroxidation product of rat brain homogenate, expressed as D-max (plasma volume in μl required for maximum inhibition of auto-oxidation). In this in vitro system, as mentioned by the authors,1 plasma containing oxidants and peroxidants fails to react.1 It is therefore not surprising that plasma with low concentrations of caeruloplasmin (which has ferroxidase activity) and high concentrations of ascorbic acid (which can reduce free iron and initiate the formation of hydroxyl radicals through Fenton chemistry) has a low D-max.1 Although ascorbic acid can act as a pro-oxidant in the presence of free transition metal ions, it is a stronger antioxidant under other oxidative stress conditions.2 Ascorbic acid scavenge a variety of reactive oxygen species, including superoxide and hydroxyl radicals, suppresses the inactivation of antiproteases by oxidants generated by the myeloperoxidase-halide system, neutralises oxidants released from stimulated neutrophils in a dose dependent manner, and can regenerate membrane bound vitamin E.3,4 Ascorbic acid also has important metabolic roles — for example, in the biosynthesis of collagen, carnitine, and catecholamines.

The question, therefore, is whether in vitro observations such as the ones made by Silvers and colleagues1 are relevant to the in vivo situation. The detection of non-transferrin bound iron in plasma of preterm and term infants4 seems to support the authors’ concerns regarding a potential pro-oxidant and antioxidant of ascorbic acid in vivo.1 However, the various antioxidant and metabolic properties of ascorbic acid also have to be considered, and the integrated effect of high plasma ascorbic acid concentrations on the health status of premature infants is unknown. Therefore, we caution readers not to conclude that ascorbic acid is harmful to premature infants and that ascorbic acid intake needs to be restricted in these infants. Only carefully designed and performed case-controlled studies of vitamin C depletion or supplementation will be able to answer these important questions.

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Dr Powers and el al comment:
There is no doubt that ascorbic acid has several important biochemical functions in the body, including, under most physiological conditions, that of antioxidant. Under the particular conditions associated with prematurity birth, however, which include a low plasma concentration of plasma transferrin and caeruloplasmin, and possibly the presence of non-transferrin bound iron, ascorbic acid present at high concentration would be expected to act as a pro-oxidant. Our published data suggest that this is indeed the case and that high plasma vitamin C concentration at birth is associated with poor outcome. As further support for this argument we have recently demonstrated that at ratios of vitamin C:caeruloplasmin which we observe in premature babies at birth, vitamin C strongly inhibits the ferroxidase activity of caeruloplasmin.1

We have not suggested that vitamin C per se is harmful to premature babies, but it is difficult to ignore the fact that Caeruloplasmin concentrations in infant formula are higher than those measured in human milk, and that formulas for premature babies are even more enriched with ascorbic acid. Our central argument is that premature babies need high intakes of vitamin C to catabolise tyrosine completely, but our stable isotope studies of tyrosine metabolism in preterm infants suggest that this is not the case. We therefore advocate a thorough re-evaluation of present recommendations for vitamin C intakes of preterm infants rather than a reassurance that current intakes are appropriate.

Dr Elbourne et al comment:
EDITOR,—All methods of ascertainment have advantages which need to be set against their potential problems for addressing particular questions. The advantages of a questionnaire to paediatricians asking them to provide information recorded previously in clinic records were largely pragmatic: it was cheap (trial funding had ended); did not require any special investigations; nor, in the context of a randomised controlled trial, was it likely to lead to a biased comparison between the treatment groups. However, as we and Dr Much point out, the method is probably not sensitive enough to detect impairments without functional loss in 2 year old children.

One way in which the sensitivity of this approach might be improved is by prospective completion of the questionnaire by the paediatrician at the time of a routine hospital check up. This may prompt a more detailed and structured assessment. Additional questions, which cannot normally be answered retrospectively from the questionnaire, may also be included. For instance, in the questionnaire used in the follow up of babies entered into a multicentre trial of the use of acetazolamide and frusmid in post-haemorrhagic ventricular dilatation, reference was made about limb and axial tone and reflex changes. This is completed by the paediatrician at the time of an outpatient clinic visit.

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Pro- or antioxidant activity of vitamin C in preterm infants?

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