Aspiration pneumonia in association with oral vitamin K

Most infants born in the British Isles now receive vitamin K prophylaxis, and the trend towards oral administration continues.1 With the awareness that vitamin K is well absorbed from the gut2 and following publication of the report linking intramuscular vitamin K and childhood cancer,3 oral vitamin K prophylaxis has become more widespread. However, because of lack of uniform national policy, the practice of vitamin K administration varies from region to region. Cases of aspiration or anaphylaxis following oral vitamin K administration have not been previously reported.

We report three cases of aspiration associated with oral vitamin K, Orakay, the preparation uniformly used in Northeast England. Acute respiratory distress developed in previously well, breast fed neonates following administration of Orakay at home. All required hospital admission, and two of them had radiological evidence of aspiration.

Case 1: A 14 day old term boy was well until the community midwife gave a second dose of Orakay by his father. He immediately developed a cough, tachypnoea, and grunting, cried inconsolably, and refused feeds. On admission, he was apyrexial but had features of respiratory distress. A chest radiograph showed infiltration of the right perihilar and lower zones. A septic screen was normal. Two further doses of Orakay were given under hospital supervision without problems and he remained well.

Case 2: A 14 day old girl was well until the community midwife gave a second dose of Orakay by her father. She started to cough, became pale, unsettled, and tachypnoeic, and refused feeds. On examination, she had features of respiratory distress. A septic screen was negative. A chest radiograph was normal. After discharge, she was given a fourth dose of Orakay under hospital supervision and remained well.

Of note, even oral administration of vitamin K can occasionally be hazardous. This is of particular concern because Orakay is not licensed in the United Kingdom. There is an urgent need to develop a consensus policy and a product that is licensed, effective, easy to administer, and has minimal adverse effect.

V Bhardari, N On Tin, S Ra Ahmed
Darlington Memorial Hospital, Darlington DL3 6HX, UK; vidyabhardari@hotmail.com

Hypothesis waiting for proof: un wrapping neonates for transfer

During transfer from the delivery suite to the neonatal intensive care unit (NICU), infants are traditionally wrapped in pre-warmed towels. Whether this is optimal remains unknown. We compared the effects on core temperature of wrapping or not wrapping neonates during their transfer from the delivery suite to the NICU.

After resuscitation, infants in both groups were transferred to a Vickers 77-transport incubator and left wrapped or unwrapped. Core temperature was recorded using a mercury thermometer before leaving the delivery suite and again, immediately after transfer into a NICU incubator. The study was granted ethical approval.

Our findings are summarised in the table. There were no significant demographic differences between the two groups. While the mean transfer time was longer in the unwrapped group, the mean temperature change during transit was lower although neither difference reached statistical significance. No hypothermia (rectal temperature <36°C) occurred in either group.

Wrapping infants in towels prevents convective heat gain. Additionally, leaving infants unwrapped allows essential clinical observation.

Despite the limitations of this small study, our findings challenge the practice of wrapping infants and warrant further examination in larger clinical studies.

D J Hawkins, D G Spedden, M Alfaham
Departments of Child Health and Medical Physics, Cardiff and Vale NHS Trust, Llandough Hospital, Cardiff CF64 2XX, UK

Correspondence to: Dr Alfaham; Mazin.Alfaham@CardiffandVale.wales.nhs.uk

Diuretics in CLD

This symposium on chronic lung disease of prematurity (CLD) by Kotecha et al1 covered important aspects and controversies in the management of CLD. We accept the authors’ inability to cover all aspects of management. We feel that some space could have been devoted to diuretics in management of CLD. Nearly all patients with CLD of some stage of their disease will receive diuretics and most of them will be on them for a long time. We came across only one systemic review by Brion et al2 in the Cochrane database. Conclusion of the authors was that there was no beneficial effect of using distal tubular diuretics for more than 4 weeks after initial stage. There was also no benefit in adding potassium sparing diuretics or newer diuretics like metalozone. Inspite of very little evidence base for diuretics in CLD, one finds nearly all CLD patients on a diuretic cocktail. In addition to their effect on electrolytes, they affect Ca/Po4 metabolism. This may exacerbate osteopenia of prematurity and may have adverse effect on lung compliance. There is a need for more discussion or clear guidelines on this issue.

V A Pai
Southmead Hospital, Bristol, UK

B Pai
Royal United Hospital, Bath, UK

Correspondence to: Flat 3, 19 Newbridge Road, Bath BA1 3HE; binapai@hotmail.com

References
1 Kotecha S. Management issues in CLD of prematurity. Arch Dis Child Fetal Neonatal Ed 2002; 87:F2

Table 1: Demographics of the two study groups and temperature difference.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Wrapped</th>
<th>Unwrapped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Male:female</td>
<td>5:5</td>
<td>3:7</td>
</tr>
<tr>
<td>Mean weight (kg)</td>
<td>1.635</td>
<td>1.595</td>
</tr>
<tr>
<td>Weight range (kg)</td>
<td>1.29–2.35</td>
<td>1.08–2.24</td>
</tr>
<tr>
<td>Mean gestation</td>
<td>32/40</td>
<td>32/40</td>
</tr>
<tr>
<td>Gestation range (d/d)</td>
<td>30–40/34–40</td>
<td>27–40/33–40</td>
</tr>
<tr>
<td>Transit time (min)</td>
<td>5 min 48 sec</td>
<td>7 min 6 sec</td>
</tr>
<tr>
<td>Range</td>
<td>4–10 min</td>
<td>5–10 min</td>
</tr>
<tr>
<td>Temperature difference</td>
<td>−0.34 °C</td>
<td>−0.21 °C</td>
</tr>
<tr>
<td>Range</td>
<td>−0.7 to +0.1 °C</td>
<td>−0.5 to +0.1 °C</td>
</tr>
</tbody>
</table>
Positioning long lines: response to Reece et al

Percutaneously inserted central venous lines are widely used in neonatal intensive care to administer parenteral nutrition and medications. It is important to ascertain the position of the line tip before use as incorrectly positioned long lines can lead to life-threatening complications like cardiac tamponade and pulmonary oedema.

Reece et al suggested that it is prudent to use a routine contrast radiograph to localise the line tip in newborns. We would like to comment on their suggestion and report a relevant case observed on our neonatal unit.

Intravenous solution is commonly used in neonates and very little is known about its potential side effects in premature infants. Studies have shown that renal clearance is prolonged in premature infants because of renal immaturity. Data in children have shown a number of possible side effects, including hypotension and cardiac arrhythmia. Moreover, obtaining an intravenous contrast radiograph of a long line would require additional medical and nursing time as a doctor would have to “grow up” for the injection. This may not be logistically feasible in some busy neonatal units, especially out of hours.

Reece et al were unable see the line tip clearly at the prick site, even after a contrast study. This was due to delay between the injection of contrast and the radiographer exposing the film. This shows that fine coordination is required between the radiographer and the person injecting the contrast. Specific training may necessary.

We performed a retrospective study of the reliability of plain radiographs in identifying the position of the line tip in our tertiary neonatal intensive care unit. Over a 10-month period all 27 babies who had long lines inserted were included. In all cases an Eptucalca-Phas-Katheter (VYGON, UK) was inserted. This is the same catheter as that used by Reece and colleagues. Our placement aim was also similar to that in their study.

The position of the line tip on the postinsertion chest X-ray was independently reviewed by an experienced junior doctor (IB) and a consultant neonatologist (SB). There was agreement between the two investigators in 25/27 (92.6%) cases. No complications due to line placement were observed during the study period.

We therefore feel that a plain radiograph is the safest, quickest, and cheapest way to ensure the safety of the line.

1. Bagchi, J A Nycky, S Bodicoat
Neonatal Intensive Care Unit, City Hospital, Birmingham, UK; bagchi@birmingham.ac.uk

References

Effect of head up tilting on oxygenation

We read with interest the paper by Dimitriou et al in which it was confirmed again that head up tilting to 45 degrees results in better oxygenation in stable preterm neonates. However compared with our study, in which the same effect was observed, there is a (probably) significant difference. Their infants were studied in the horizontal prone, in the horizontal supine and in the 45° head up tilt supine position whereas in our study all infants were studied in the prone position including the 45° head up tilt. We had then hypothesised that the combination of the prone position and the 45° head up tilt could facilitate diaphragmatic activity.

I do not think that this hypothesis can be totally dismissed by the results of Dimitriou et al as suggested by the authors, since their infants were studied in different postures that is, supine in their study and prone in our study.

HD Dellagrammaticas
1delagrar@uth.forth.gr

References

Authors’ reply

We thank Professor Dellagrammaticas for his comments on our study. 1 Dellagrammaticas et al hypothesised that the combination of the prone posture and the 45 degree head up tilt position could facilitate diaphragmatic activity. We however, propose that the improvement in oxygenation seen in the head up tilt position was more likely to be due to a change in lung volume. In the head up tilt position, the weight of the abdominal contents on the diaphragm is reduced, tending to increase functional residual capacity. 1 In contrast, ultrasonographic examination 2 has demonstrated that the diaphragm was significantly thicker at end expiratory volume in the prone rather than the supine position, which is likely to result in reduced diaphragm strength. Indeed, we demonstrated 3 that the effect of respiratory muscle strength was lower in the prone compared to the supine position and the supine position with 45° head up tilt.

A Greenough, G Dimitrou
Children Nationwide Regional Neonatal Intensive Care Unit, King’s College Hospital, London, UK
Correspondence to Professor Greenough, Department of Child Health, King’s College Hospital, London, SE5 8RS, UK; anne.greenough@kcl.ac.uk

www.archdischild.com
sodium depletion, and hyponatraemia, ignored; for example, renal salt wasting, homoeostasis in premature infants has been revealing some major features of sodium

trary. In particular, the work of our group in important ethical issue, in that I regard their

10–13 years of age

neurodevelopmental outcome at

newborn premature infants on

performances at the age of 10–13 years in pre-

memory, learning, language, and educational


Effect of salt supplementation of newborn premature infants on neurodevelopmental outcome at 10–13 years of age

I read with interest the report by Al-Dahhan and colleagues’ on the beneficial effect of NaCl supplementation of preterm infants during the neonatal period on their later neurodevelopmental outcome. They found better memory, learning, language, and educational performances at the age of 10–13 years in pre-

matures who were given 4–5 mmol/day NaCl when compared with those not receiving NaCl supplement. In this regard it is relevant to mention our most recent findings describing a new aspect of the relation of neonatal sodium homeostasis to central nervous system function. Namely, we showed that hyponatraemia is one of the most significant risk factors for development of sensorineural hearing impair-

ment detected by transient evoked otoacous-

tic emission and confirmed by auditory brain-

stem response. In addition, I consider their report raises an important ethical issue, in that I regard their selection of references as subjective and arbitrary. In particular, the work of our group in revealing some major features of sodium homeostasis in premature infants has been ignored; for example, renal salt wasting, sodium depletion, and hyponatraemia, and the first introduction of NaCl supplementation in a dose of 3–5 mmol/kg/day to prevent

specifically designed to examine neurodevelop-

mental outcome in two particular groups of infants previously studied by ourselves. His recent study of hyponatraemia and sen-

sorineural deafness in preterm infants’ had not been published when our paper was submitted to the Archives, although we would certainly have referred to it if it had been.

G Haycock

References


Author’s reply

Methinks Professor Sulyok doth protest too much. His early, pioneering work on electro-

lyte balance in the newborn is well known, and extensively cited in an earlier review of the subject co-authored by myself. In this, inter alia, his study of the effect of salt supplementation on the renin-angiotensin-

aldosterone system[2] is quoted in support of the hypothesis that hyponatraemia in prematu-

preneumature infants is due to salt depletion rather than water retention. The reason these papers were not cited in the present paper is that they are not relevant to it. The paper is not a historical or general review of hyponatraemia in the newborn but the results of a study

specifically designed to examine neurodevelop-

mental outcome in two particular groups of infants previously studied by ourselves. His recent study of hyponatraemia and sen-

sorineural deafness in preterm infants’ had not been published when our paper was submitted to the Archives, although we would certainly have referred to it if it had been.

G Haycock

References


Positioning long lines: response to Reece et al

I Bagchi, J A Nycyk and S Bodicoat

Arch Dis Child Fetal Neonatal Ed 2002 87: F233
doi: 10.1136/fn.87.3.F233

Updated information and services can be found at:
http://fn.bmj.com/content/87/3/F233.1

These include:

References

This article cites 4 articles, 1 of which you can access for free at:
http://fn.bmj.com/content/87/3/F233.1#BIBL

Email alerting service

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/