The importance of irradiance and area in neonatal phototherapy
G Hart, R Cameron


Background: Despite a long period of development, there are still considerable variations in the spectral output, the levels of irradiance, and irradiated area provided by commercial phototherapy systems. These variations depend on the types and output of the lamps used to produce the phototherapy, along with the design of the systems, and principally on whether the phototherapy is provided from overhead or underneath.

Objective: To see whether commercially available phototherapy systems produce sufficient irradiance over the surface area of the neonate.

Methods: Surface plots of the output irradiance were made on a number of systems and used to calculate the effective irradiance on the surface of a premature or term baby, using mapped outlines.

Results: A 10-fold difference in peak central irradiances was found between the systems tested, with a fourfold to fivefold difference in effective irradiance to the baby surfaces. Although work published over 20 years ago showed that levels of irradiance should reach 2 mW/cm² to achieve optimal effectiveness, some of the commercial systems tested do not appear to achieve this level.

Conclusion: Purchasers of neonatal phototherapy systems need to take into account whether the systems will produce sufficient irradiance over the area to ensure maximal effect, to keep the treatment time to a minimum.

A recent report from the American Academy of Pediatrics on neonatal hyperbilirubinemia confirms the efficacy of phototherapy as a treatment. Despite the long period of development since the original paper of Cremer et al, there are still considerable variations in the spectral output, levels of irradiance, and irradiated area provided by commercial phototherapy systems. This was noted in the American Academy of Pediatrics report.

It is clear that the irradiance produced by phototherapy systems is an important factor. Many authors have shown that increasing irradiance produces a faster rate of fall of serum bilirubin. Tan showed over 20 years ago that irradiances of 2 mW/cm² (~40 μW/cm²/mm) are needed before a possible plateau response in the rate of bilirubin degradation is reached. Nevertheless, some current commercial phototherapy systems do not produce these irradiances.

Bringing the lights closer could increase the irradiance of overhead phototherapy systems. As this cannot easily be achieved for neonates in incubators, one solution is to provide phototherapy from underneath, as the neonate thus lies closer to the lights. This has been shown to be more effective than conventional overhead phototherapy.

Another solution is to provide phototherapy from both above and below. This also seems to show a greater level of efficacy than overhead phototherapy alone.

The other parameter that affects the effectiveness of phototherapy is the area of the neonate irradiated by the system. Maisels highlighted the need to consider this issue, and it was also used by Dicken et al, Vreman et al, and Wentworth in the assessment of the overall performance of phototherapy systems.

The above appear to confirm the idea that many conventional phototherapy systems do not produce sufficient irradiance to maximise the degradation of bilirubin.

If overhead phototherapy does indeed reach Tan’s plateau value of optimum irradiance, logic suggests that the way to increase the effectiveness of phototherapy would be to effectively double the treatment area by irradiating the neonate from below as well as above.

MATERIALS AND METHODS

The effective irradiance of a number of phototherapy systems was assessed by taking a series of irradiance measurements at 2 cm intervals in the illuminated field. Measurements were made using an International Light IL1700 radiometer with an SED033 detector, a “BR” bilirubin filter, and a “W” cosine diffuser. The radiometer and detector were calibrated against a secondary standard spectroradiometer, using a Philips TL52 phototherapy lamp as the light source.

All measurements for the overhead phototherapy systems were made with a source to measurement distance of 45 cm at the centre of the field, representing a typical treatment distance for neonates in incubators. For the fixed or underneath systems, measurements were made on the surface of the treatment area for that system, which included a blue-green gel mattress (JLJ Healthcare, Halesowen, West Midlands, UK). Measurements were made until the output had fallen to about 10% of the peak value or until the sides of the crib had been reached.

The method used for the irradiance mapping was similar to that used by Dicken et al and Vreman et al. The data were entered into Excel spreadsheets and then linearly interpolated from the 2 cm grid used during the measurement process into a 1 cm grid to aid the mapping process. Outlines of both a premature and a term baby were then mapped and entered into the spreadsheets. The only significant difference from the approach of Vreman et al is the use of an ellipsoidal model to simulate the curved edges of the body. This model suggested that the effective irradiance within 1 cm of the edge of the head and body should be reduced from 100% to 80%, and to 50% for the arms and legs, which reduces the overall effective irradiance by ~14%.

Figure 1 shows the outline for the premature baby.
Each cell within the outlines was then multiplied by the corresponding interpolated irradiance values, centring the outlines of the premature and term babies at the centre of the irradiance fields. Values of the total irradiance were then calculated for the whole irradiated surface to assess the relative effectiveness of the phototherapy systems under test.

However, because neonates are known to move within the incubator or crib, the calculations were repeated with the outlines translated by 4 cm (and where possible 8 cm) in both the x and y directions to assess whether this would make any difference to the received irradiance.

**RESULTS**

Measurements were made on a number of phototherapy systems:

- Hill-Rom Microlite, overhead unit based on white light sources;
- Draeger Phototherapie 800, overhead unit using a blue metal halide lamp;
- Medestime Duo, which has two independent overhead units, each containing four blue compact fluorescent lamps;
- Natus neoBLUE, overhead unit using a blue LED array (used here on its high output setting);

![Figure 1](image)

**Figure 1** Premature baby outline, showing the weighting factors used in the calculation of total effective irradiance.

![Figure 2](image)

**Figure 2** Surface plots for (A) Microlite, (B) Draeger, (C) Duo, and (D) neoBLUE phototherapy systems. The plots show a three dimensional representation of the irradiance produced by the phototherapy systems over the area of the crib. Irradiance on the vertical axis is measured in mW/cm². The horizontal axes represent distance on the crib surface.
Medestime Bilicrystal IV2, a dual phototherapy system based on six blue compact fluorescent lamps in an underneath unit, with a further five compact fluorescent lamps in a fixed overhead unit;

Medela Bilibed, using a single blue compact fluorescent lamp underneath, with the baby lying on a blue-green gel mattress;

A Medela Bilibed, modified in-house at Bradford as an experimental unit. This unit contained 800 Nichia NSB500 blue LEDs as the light source, with the baby lying on a blue-green gel mattress.

Figures 2 and 3 show the surface plots of the different units tested. All surface plots are plotted on the same vertical scale to aid direct comparison of the systems.

Table 1 gives the results of the measurements and calculations of total surface irradiance for both term and premature neonates. The ratio figures were obtained by dividing the mean of the moved total irradiance figures by the central total irradiance.

**DISCUSSION**

The surface plots in figs 2 and 3 clearly show the large differences in measured irradiance of the systems tested. This is mirrored in the total irradiance figures given in table 1.

The plots appear to show that the systems with lower levels of irradiance have a more even irradiance field than the higher output systems. Although this is true in absolute terms, the lower irradiance systems also show a similar percentage fall between centre and edge.

Three of the systems tested did not reach Tan’s 2 mW/cm² central irradiance figure and also delivered lower total effective irradiances, which implies that they will not be as clinically effective as units that produce a greater level of irradiance.

Bringing the overhead units closer to the surface of the neonate would undoubtedly increase the measured irradiance, as the irradiance from an extended source is approximately proportional to 1/distance from the source. This is usually not an option for a neonate being treated in an incubator, and for neonates in cribs the level of heat generated by the lights also has to be taken into account.

The underneath systems show a significantly higher level of irradiance than the overhead systems, principally because of the closeness of the light sources to the baby’s skin surface. In these systems, the light has in fact been attenuated by the use of the gel mattress, which scatters the light and reduces the irradiance at the surface of the neonate by about 30%. Use of a less attenuating surface would lead to a further increase in the irradiance.

The surface plot for the experimental LED array (fig 3D) shows a bimodal irradiance distribution, caused by the layout of the LEDs in two square panels with a small central gap. The resolution of the reduced irradiance between the panels...
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