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 irradiation 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.

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 (JLI 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, similar to that of Vreman et al., were then mapped on to other 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):
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...
shows the sensitivity of the method to changes in the shape of the light field.

Although there is a clear relation between the central irradiance value and the overall total irradiance figures for the term and premature baby outlines, they do not correlate perfectly. This is because of differences in the shapes of the light fields, and shows that both the peak irradiance and the area irradiated must be considered when seeking to assess the overall likely clinical effectiveness of the system.

Moving the outline by either 4 cm or 8 cm over the irradiated field did not appear to lead to a significant change in the level of irradiance. This was not done for either the Medela Bilibed or the modified unit containing the LED array, as the units are designed so the baby remains in a fixed position relative to the lights.

The irradiance measurements here were all made with a fixed bandwidth broad band radiometer. Maisels’ reminds us that we have to be careful about “measuring” irradiance, and Costarino et al. go further, saying that “information obtained from a fixed band width radiometer designed to measure radiant flux in the blue light range may not allow meaningful comparison of phototherapy units in the clinical setting”. This problem occurs because of the widely differing spectra of phototherapy systems. Some authors have decided to use spectroradiometric measurements, such as Wentworth, who integrated the spectra from 400–550 nm.

However, using this kind of technique means that wavelengths outside the usually accepted action spectrum will contribute to the “useful” measured irradiance. The BR filter attached to the detector in our measurements is set to allow wavelengths in a 50 nm band centred on 450 nm, to match the action spectrum of Cremer et al. The comments of Costarino et al. assume that wavelengths outside the blue region make a positive contribution to phototherapy. If this is not the case, however, measurement devices such as the one used here do indeed provide a reasonable way of assessing the useful irradiance of phototherapy systems. Most evidence thus far appears to support the action spectrum of Cremer et al and so this was used.

Reviews such as those produced by the UK’s Medicines and Healthcare Products Regulatory Agency highlight the value of comparing systems using the same measurement techniques and equipment. This paper also shows that direct comparisons can show significant differences between commercially available systems of both the central and total effective irradiance over the surface of the neonate.

Purchasers of neonatal phototherapy systems need to take into account whether the systems will produce sufficient irradiance over the area required to ensure that the phototherapy is maximally effective, as this is likely to reduce the time that the neonate needs to undergo the treatment.

Table 1  Peak and integrated irradiances of the systems under test, together with the ratios of the total irradiance when the outlines were moved 4 cm and 8 cm

<table>
<thead>
<tr>
<th>System</th>
<th>Central peak irradiance (mW/cm²)</th>
<th>Central peak irradiance (µW/cm²/nm)</th>
<th>Term baby total irradiance at centre (mW)</th>
<th>Prem baby total irradiance at centre (mW)</th>
<th>Ratio 4 cm:centre</th>
<th>Ratio 8 cm:centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hill-Rom Microlite</td>
<td>1.20</td>
<td>~24</td>
<td>319</td>
<td>236</td>
<td>0.98</td>
<td></td>
</tr>
<tr>
<td>Droeger Phototheraphy</td>
<td>1.70</td>
<td>~34</td>
<td>575</td>
<td>366</td>
<td>0.97</td>
<td>0.97</td>
</tr>
<tr>
<td>Medestime Duo</td>
<td>1.94</td>
<td>~34</td>
<td>628</td>
<td>594</td>
<td>0.99</td>
<td>0.97</td>
</tr>
<tr>
<td>Natus neoBLUE</td>
<td>3.36</td>
<td>~65</td>
<td>1118</td>
<td>711</td>
<td>0.97</td>
<td>0.95</td>
</tr>
<tr>
<td>Bilicrysal IV2 (top unit)</td>
<td>3.08</td>
<td>~62</td>
<td>1034</td>
<td>684</td>
<td>0.99</td>
<td></td>
</tr>
<tr>
<td>Bilicrysal IV2 (under unit)</td>
<td>10.57</td>
<td>~211</td>
<td>2744</td>
<td>2033</td>
<td>0.97</td>
<td></td>
</tr>
<tr>
<td>Medela Bilibed</td>
<td>7.82</td>
<td>~156</td>
<td>1156</td>
<td>953</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LED Bilibed</td>
<td>11.72</td>
<td>~234</td>
<td>1333</td>
<td>1215</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ACKNOWLEDGEMENTS

We acknowledge Medela for providing two Bilibeds for use in these measurements. We are grateful for permission to modify one of the Bilibeds, which was converted to hold the blue LED array. We are, however, responsible for the design and performance of the experimental LED array. We also thank Jackie Lloyd-Jones of JLI Healthcare for the loan of the Medestime phototherapy equipment. We are grateful to Hugh Morrison for making many of the measurements that formed the surface irradiance mapping, and to Marina Hart, Stephanie Wentworth, and Diane Crawford for their many helpful comments during the writing of the final script.

Authors’ affiliations
G Hart, R Cameron, Medical Physics Department, Bradford Royal Infirmary, Bradford BD9 6RJ, UK

Funding: This project was funded through an NHS R&D programme at Bradford Teaching Hospitals NHS Foundation Trust.

Competing interests: none declared

REFERENCES
The importance of irradiance and area in neonatal phototherapy

G Hart and R Cameron

Arch Dis Child Fetal Neonatal Ed 2005 90: F437-F440 originally published online May 4, 2005
doi: 10.1136/adc.2004.068015

Updated information and services can be found at:
http://fn.bmj.com/content/90/5/F437

These include:

References
This article cites 9 articles, 4 of which you can access for free at:
http://fn.bmj.com/content/90/5/F437#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.

Topic Collections
Articles on similar topics can be found in the following collections
Physiotherapy (49)

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/