Temperature variation in newborn babies: importance of physical contact with the mother

A-L Fransson, H Karlsson, K Nilsson

Background: Hypothermia is a major cause of deterioration and death in the neonatal period. Temperature deviations are key signs of illness.

Objective: To determine normal patterns of temperature variation in newborn babies and the influence of external factors.

Methods: Abdominal and foot skin temperature were continuously recorded in 27 healthy full term babies during the first two days of life and related to the care situation—that is, whether the baby was with the mother or in its cot. The recordings were made using no wires to avoid interference with the care of the neonate. Ambient temperature was close to 23°C during the study period.

Results: Mean rectal and abdominal and foot skin temperature were lower on day 1 than day 2. The foot skin temperature was directly related to the care situation, being significantly higher when the baby was with the mother. The abdominal skin temperature was much less influenced by external factors. When the neonates were with their mothers, the mean difference between rectal temperature and abdominal skin temperature was 0.2°C compared with a mean difference between rectal temperature and foot skin temperature of 1.5°C, indicating a positive heat balance. In the cot the corresponding temperature differences were 0.7°C and 7.5°C. A temperature difference between rectal and foot skin temperature of 7–8°C indicates a heat loss close to the maximum for which a neonate can compensate (about 70 W/m²).

Conclusion: This study emphasises the importance of close physical contact with the mothers for temperature regulation during the first few postnatal days.

Materials and Methods

After approval from the medical ethics committee of the medical faculty and parental informed consent, abdominal and peripheral skin temperatures of 27 newborn healthy babies were measured continuously during the first two days of life. Measurements started four to eight hours after birth.

To obtain the longest possible measurement period, babies born during the night were selected. The mean recording period was 19 hours and 22 hours on the first and second day respectively.

The infants wore disposable nappies (heat insulation 0.44 m²°C/W measured by a TOG meter; ISO11092) and were dressed similarly; they wore a vest (0.04 m²°C/W), underpants (0.03 m²°C/W), and rompers (0.08 m²°C/W). All clothes were made of cotton fabric. In the cot, neonates were covered by a cotton blanket (0.39 m²°C/W).

Central skin temperature was measured laterally below the umbilicus under the nappy. Peripheral skin temperature was measured on the sole of the foot. Skin temperature was recorded once a minute with thermistors, and the values stored continuously on a PC. The thermistors (Novametric AB, Göteborg, Sweden) measured 40 × 35 × 6 mm and were made of polymer with an approximate specific conductivity of 0.03 W m/°C corresponding to a heat insulation of 0.02 m²°C/W. They were attached to the skin using a thin adhesive tape (Micropore 3M). Recordings of skin temperature were transmitted wirelessly to a battery back up receiver located under the neonate's mobile bed. The transmitter range was about 10 m, allowing unrestricted care within the room and in the hospital, as the mobile cot was normally taken with the neonate when parents moved around with their baby. Total loss of measurements from the skin thermometers was 10–11% of possible recordings as a result of external interference or because a child was not within reach of the receiver. The thermistors were calibrated in a temperature certified water bath. A maximum variation of ± 0.2°C within the 27–40°C measurement range was recorded. T½ was one minute.

After each completed period, data were transferred to a PC for processing. Figure 1 shows a complete recording from one child. Environmental air temperature was recorded at the

same time as the skin temperature and stored in the same way as the skin temperature. The rectal temperature was recorded morning and evening.

The relative air humidity was recorded using a hair hygrometer with an accuracy of ±5%.

The mothers were given a log sheet to record the times of specific activities: feeding; nappy changes; whether the child was in its cot or with the mother; changes of clothing. Completion of the log sheet was voluntary. To avoid interference with normal bonding, no pressure was put on the mothers with regard to precision, intervals, or description of the events.

Mean rectal and abdominal and foot skin temperature were calculated for days 1 and 2. Periods of one hour or more when the foot skin temperature was highest or lowest were identified on the first and second day. Simultaneous abdominal skin temperatures were used for calculation of peripheral to central skin temperature difference during these periods and related to the care situation—that is, whether the baby was with the mother or in its cot (fig 1). The results for one neonate were excluded because of an incomplete diary.

The rate of increase in abdominal and foot skin temperatures (°C/h) after a period of low temperature was calculated. For the recordings of foot skin temperature, a stable increase over one hour was required. For the abdominal skin temperature, a stable increase over 30 minutes was accepted, as the preceding reduction in temperature was usually small (fig 1).

Data processing

The mean abdominal, foot, and ambient temperatures were calculated and related to rectal temperatures for the whole period and separately for days 1 and 2. All results are presented as mean (SD).

Statistical analysis was carried out using paired Student’s t test for comparisons of measurements from the same baby on days 1 and 2 and unpaired Student’s t test for comparisons between different babies on days 1 and 2. p<0.05 was taken as significant.

RESULTS

The neonates were treated as one group as no significant differences were found between the 16 boys and 11 girls with

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Temperatures (°C) on days 1 and 2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Day 1</td>
</tr>
<tr>
<td>Rectal</td>
<td>37.07 (0.31)</td>
</tr>
<tr>
<td>Abdomen</td>
<td>36.52 (0.59)</td>
</tr>
<tr>
<td>Foot</td>
<td>31.85 (1.73)</td>
</tr>
<tr>
<td>Ambient</td>
<td>23.06 (0.75)</td>
</tr>
</tbody>
</table>

Values are mean (SD).

*p<0.05, **p<0.01 compared with day 1.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Highest and lowest foot skin temperatures (°C) during a stable one hour period on days 1 and 2 in relation to abdominal skin temperature and ambient temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Day 1</td>
</tr>
<tr>
<td>Highest</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>36.88 (0.66)</td>
</tr>
<tr>
<td>Foot</td>
<td>35.50 (1.15)</td>
</tr>
<tr>
<td>Difference</td>
<td>1.38 (0.49)</td>
</tr>
<tr>
<td>Ambient</td>
<td>23.05 (0.99)</td>
</tr>
<tr>
<td>Lowest</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>36.19 (0.62)</td>
</tr>
<tr>
<td>Foot</td>
<td>29.37 (1.80)</td>
</tr>
<tr>
<td>Difference</td>
<td>6.87 (1.61)</td>
</tr>
<tr>
<td>Ambient</td>
<td>23.21 (0.77)</td>
</tr>
</tbody>
</table>

Values are mean (SD).

*p<0.01 compared with day 1.
regard to gestational age (mean (SD) 40 (1.2) weeks), birth weight (3630 (481) g), length (50.7 (2.1) cm), and mean rectal or skin temperatures.

**Mean rectal and abdominal and foot skin temperature on days 1 and 2**

Abdominal skin temperature was always higher than foot skin temperature (p<0.001).

The mean abdominal skin, foot skin, and rectal temperatures for the 27 children were significantly lower on day 1 than day 2 (table 1). The relative air humidity during the measurement periods was 40 (10)% with no significant difference between days 1 and 2.

**Periods of highest and lowest foot skin temperature on days 1 and 2**

Mean foot skin and abdominal skin temperatures for periods of more than one hour when the foot skin temperature was highest and lowest were calculated for the whole group (n = 26; recordings from one neonate were incomplete). There were no significant differences between days 1 and 2. The difference between abdominal skin temperature and the highest foot skin temperature was 1.38 (0.49) °C and 1.36 (0.95) °C on days 1 and 2 respectively. The corresponding differences for the lowest foot skin temperature were 6.77 (1.61) °C and 6.68 (1.46) °C (table 2).

**Foot skin temperature when the baby was with the mother and in the cot**

Log sheets that were sufficiently detailed were used to compare skin temperatures when the neonates were in close contact with the mothers and when lying alone in their cots. Six protocols, with periods between notes of less than three hours, were selected. Periods with a foot skin temperature less than the mean of the whole measurement period on days 1 and 2.

The periods of high foot skin temperature made up 7.8 (3.3) hours of the whole study period of 41 (9.3) hours, and those of low foot skin temperature made up 9.0 (4.5) hours.

**Ability to increase skin temperature**

The speed of increase in skin temperature was significantly greater for the foot than for the abdomen (table 4). There was no significant difference between days 1 and 2 for either location.

When all periods of increased foot skin temperature (heat saving) were added together, they made up 52% and 33% of the observation period on days 1 and 2 respectively.

**DISCUSSION**

Peripheral and central skin temperature in 27 healthy newborns during the first two days of life were continuously analysed by wireless temperature sensors. All neonates were cared for by their mothers on the ward. The mothers kept diaries about the care situation, noting when the neonates were in close contact themselves and when lying in the cot. All mothers reported that the temperature sensors did not interfere with the care of their babies. The local insulation added by the sensors was 2% and 3% of the total for the abdomen (with nappy, underpants, and cotton blanket) and foot (with rompers and cotton blanket) respectively. This may delay changes in skin temperature caused by a rapid change in the environment but only marginally influence

<table>
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<tr>
<th>Table 3</th>
<th>Temperature difference (°C) for all abdominal and foot skin temperature periods in which the foot skin temperature was 2°C higher (baby with mother) or 2°C lower (baby in the cot) than mean foot skin temperature for the whole measurement period</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>With mother</td>
</tr>
<tr>
<td></td>
<td>Abdominal/foot</td>
</tr>
<tr>
<td>Total</td>
<td>36.93/35.36</td>
</tr>
</tbody>
</table>

Differences are mean (SD). **p<0.01, ***p<0.001 compared with when the baby was with the mother.
What is already known on this topic

- Temperature regulation in newborn babies has been studied during short periods of time and under experimental conditions.

What this study adds

- We have studied the natural pattern of temperature variations in newborn babies and the influence of changes in environmental conditions during routine care during the first two days of life.

Ability to increase skin temperature

Decreases in abdominal skin temperature were always associated with a change of nappy. The subsequent maximal abdominal skin temperature increase was 2.1–2.4°C/h (table 4).

The foot skin temperature increased by 4.8–5.1°C/h when a child was taken from the cot to the mother (table 4). Foot skin temperature increased from the lowest to the highest level within two hours.

In a previous study, deep body temperature increased by 0.7°C/h during skin to skin care periods in term, newborn babies with an initial rectal temperature of 36.3°C.

Heat losses

Adamson et al5 showed that oxygen consumption correlated with the ambient to mean skin temperature difference (external temperature gradient) but not with the rectal temperature.

Measurement of dry heat losses confirms that heat losses are determined by the external temperature gradient in neonates.5,5,7 Clothing changes the dimension of the heat loss but not the correlation.

Information from the limited number of studies allowing quantification of dry heat loss from neonates from direct whole body calorimetry13 or weighted direct calorimetry14 in relation to the difference between core and foot skin temperature can be combined to illustrate heat loss over a range of core-foot skin temperature differences (fig 2). For all these references12,15 values from diagrams of dry heat loss have to be combined with diagrams presenting core temperature and foot skin temperature.

The temperature difference of 7°C between abdominal and foot skin recorded for the neonates when in the cot corresponds to a heat loss of about 70 W/m². A difference of 2°C recorded when the neonate was kept next to the mother’s skin corresponds to a heat loss of 20 W/m².

The mean abdominal to foot skin temperature difference of 5°C for the whole study period corresponds to a mean heat loss of 50 W/m². Under optimal environmental conditions (temperature neutral zone) the heat loss from term babies is about 35 W/m².14,15,7,16 Losses of 70 W/m² are close to the maximum for which a neonate can compensate.7 A loss of 20 W/m² allows heat storage and compensation for the losses experienced when cared for in the cot.

The maximal measured rectal temperature during the study period was 37.5°C, and sweating was never reported. Sweating has been reported to occur in newborn babies with a core temperature of 37.3°C or more in combination with a temperature difference of less than 1°C.4

CONCLUSIONS

This study emphasises the importance of close physical contact with the mothers for temperature regulation during the first few postnatal days. In the maternity ward studied, periods of cot care resulted in peripheral skin temperature changes indicating heat losses close to compensatory capacity. During periods of skin to skin care, peripheral and abdominal skin temperature increased indicating a heat gain.
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