Spot urine samples for evaluating solute excretion in the first week of life

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Abstract

**Aim**—To evaluate whether the urinary creatinine concentration is a reliable reference value to standardise urinary solute excretion in a spot urine sample during the first week of life.

**Methods**—Spontaneously voided urine specimens were obtained in 48 healthy, full term neonates, aged 1 to 6 days (median 2.4) and in 168 healthy older children with a median age of 1.5 years (range 1 month to 3 years). In 62% of the children two urine samples were available with an interval of 2 to 4 (neonates) and 7 days (older children).

**Results**—In neonates both the urinary creatinine concentration and the urinary creatinine:osmolality ratios were significantly higher than in the older children, and were spread over a wider range. During the first postnatal week of life the mean urinary creatinine and urinary creatinine:osmolality ratio values in the first urine sample were also significantly higher than in the second samples. In children aged between 1 month and 3 years of age, these data were remarkably stable without any significant changes between repeat urine samples.

**Conclusions**—The urinary creatinine concentration during the first days of life is high and variable, even when corrected for urinary osmolality. This is the opposite of what is found in older children and adults. Urinary creatinine and the urinary creatinine:osmolality ratio, therefore, cannot be used to standardise the urinary excretion of solutes in the first week of life.

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Keywords: spot urine sample; urinary creatinine; osmolality ratio; urinary solute excretion

Without invasive techniques such as bladder catheterisation, accurate urinary collections are notoriously difficult to obtain in young children, especially in neonates. It is therefore understandable that methods which eliminate the need for the gold standard of timed urine collections are constantly being sought. Several studies have used the urinary solute:creatinine ratio in a single urine specimen to quantify the urinary excretion of various substances in neonates, infants, and children.10 When a urinary solute concentration was related to the urinary creatinine excretion, which is usually constant and related to the size and weight (muscle mass) of the individual, a measure of functional renal developmental maturation was added to the calculation. These studies were modifications of the idea first proposed by Nordin in adults.10 None of these studies has, however, shown that urinary creatinine can serve as a reliable reference standard during the first week of life. Our study aimed to answer this question.

**Methods**

Urine samples from 216 young children were tested. Urine samples from 48 neonates 1 to 6 days (mean 2.4) old were obtained from the University Maternity Hospital of Lausanne. The urine samples from infants/toddlers/children from the age of 1 to 6 months (n=38), 6 to 12 months (n=41), 12 to 24 months (n=48) and 24 to 36 months (n=41) were collected in nurseries and kindergartens in Lausanne.

Written, informed consent was given by all parents and the research protocol was approved by the ethics committee of Lausanne Medical School.

Only healthy, term neonates (gestational age 38 to 41 weeks) without a family history of kidney or metabolic disease were included in this study. A spontaneously voided, random urine sample was collected between 6 am and 11 am. Standard, sterile, adhesive plastic bags were used for neonates and children who were not toilet trained. In 62% of the children an additional second urine sample was obtained after 2 to 4 days (neonates/infants, n=47, first sample, n=33 for second sample) or one week (all older children, n=168 for first sample; n=76 for the second).

The urine samples were transferred to chemically clean bottles and analysed within 3 hours. The urinary creatinine concentration (Ucreat) was determined using a kinetic Jaffé reaction (Hitachi 704 autoanalyser; reagents by Boehringer–Rotkreuz, Switzerland). The interference coefficient of variation of this method was <4% at Ucreat concentrations of 6 mmol/L. Urinary osmolality (Uosm) was measured by freezing point depression (Microsmometer type 13, Roebling CE, Merck AG, Zurich, Switzerland).

Differences in the results between the sexes and between the two urine samples from the same child were evaluated using the Wilcoxon signed rank test. The sex data were paired for day of age. The median values of Ucreat concentrations as well as the Ucreat:osmolality ratios were compared for the 1–6 day old neonates and the older children using the Wilcoxon rank sum test. The distribution of the data are presented as box and whisker plots. The data are given as median and range;
**Results**

The median value of Ucre in the neonates (7060 µmol/l, range 680–19300) differed significantly (<0.0001) from that of older children (1961 µmol/l, range 260–9970) (fig 1). These numbers also show that the scatter of the creatinine values at birth was far greater than at a later age (figs 1–3). The mean Ucre:osmolality ratio of the neonates was 19.7 µmol/mOsm/kg/H_2O (range 7.9–40.5) and 5.2 (range 2.7–17.6) for the older children (<0.0001) (fig 2). No significant differences were found between the sexes. There was, however, a significant difference (<0.0001) for both Ucre and Ucre:osmolality values between the two urine samples in the neonates, with the highest values found in the first urine sample (fig 3A). For those aged between 1 month and 3 years of age, both urine values were comparable and remained remarkably stable (figs 1 to 3B).

**Discussion**

The production of creatinine is related to total lean body mass, which generally does not change within relatively short periods of time. When serum creatinine concentrations are constant, the glomerular filtration rate (GFR) is stable and tubular secretion and reabsorption of creatinine (in health at most ages) is minimal, the rate of elimination of creatinine from the body does not fluctuate very much. This steady state is the rationale for using the Ucre concentration as a reference standard for the chemical analysis of a spot urine. The urinary solute:creatinine ratio was therefore considered to be a rather useful and reliable tool both in children and adults, as well as non-invasive, convenient, sensitive and relatively inexpensive.

Our study set out to ask whether the Ucre is indeed stable in the early neonatal period. The results clearly show that this is not the case. The mean Ucre concentration was significantly higher in neonates than in older children (fig 1). This difference remained almost unchanged when the Ucre concentration values were corrected for changes in urine dilution and concentration by factoring Ucre by Uosm (fig 2). More important, however, is the great scatter in the Ucre:osmolality ratio values during the first week of life and the significant fall in these values within 48 hours (fig 3A). This contrasts with the picture seen in older children and adults. The latter also tend to have a large scatter in Ucre due to wide variability in urinary volumes. At that age the influence of volume changes can be minimised after factoring the Ucre data with Uosm. Recently Moore et al proposed a validation of this approach for the screening of albuminuria in spot urine samples of adult patients with correction by the specific gravity of the urine sample. As shown by us, these forms of corrections are, however, not valid in the immediate newborn period. A similar impression was reported by Karlsson et al when studying urinary protein excretion in neonates.

We would have preferred to compare the reported spot urine results with normal data obtained by complete, timed urine collections. This would have been the ultimate proof of our assertion that Ucre is an unreliable reference value in the early newborn period. This would,
however, have required bladder catheterisation of healthy neonates, which could obviously not be undertaken. Given these ethical constraints, the correction of Ucreat by Uosm was the only practical alternative.

The scatter of Ucreat can not be explained by differences in lean body mass, because all the babies were healthy, full term newborns with birthweights appropriate for their gestational ages. Other lines of evidence may, however, shed light on our findings. It has to be remembered that creatinine is a small compound (radius 0.5 nm; molecular weight 113 Daltons) which easily passes the placental barrier. During the first days of extrauterine life the baby’s serum creatinine concentrations therefore largely represent those of the mother. This changes rapidly after birth with neonatal serum creatinine values more or less stabilising within 1 to 3 weeks, depending on gestational age. During postnatal anabolic growth muscle mass will increase, thus adding to changes in serum creatinine concentrations and urinary excretion of creatinine. Obviously, the tubular delivery and handling of creatinine also undergo rapid developmental changes, mainly due to the postnatal increase in GFR, which almost doubles within two weeks of birth mainly due to the postnatal increase in GFR, also undergo rapid developmental changes, the tubular delivery and handling of creatinine and urinary excretion of creatinine. Obviously, muscle mass will increase, thus adding to

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10 Nordin BEC. Assessment of calcium excretion from the urinary calcium/creatinine ratio. Lancet 1959;i:368-71.