The results of genotyping analysis of the BUGT1 gene in 55 healthy infants are given in Table 1. The one variant homozygote was omitted from the statistical analysis. The serum bilirubin concentration at 4 days of age in this infant was 9.1 mg/dl. In the healthy infants no significant difference was detected in serum bilirubin concentrations at 4 to 5 days of age between normal homozygotes (10.0 (2.7) mg/dl; mean (SD)) and heterozygotes (9.2 (1.5) mg/dl; p = 0.45, unpaired Student’s t test).

We also analysed 19 infants with jaundice requiring treatment; 18 normal homozygotes and one heterozygote. Thus the TA-7 allele was found only in one of 19 cases. The peak serum bilirubin concentrations in the 18 normal homozygotes were 18.8 (2.29) mg/dl and that in the heterozygote was 15.7 mg/dl. TA-7 allele frequency was calculated to be 0.07, significantly lower than the value of 0.4 found in the North American and Eastern Scottish populations (p < 0.001, 2 analysis with one degree of freedom). The genotype distribution in the 74 Japanese infants was also significantly different from that found in the North American and Eastern Scottish populations (p < 0.001, 2 analysis with two degrees of freedom).

Ethnic differences in the incidence of neonatal jaundice have been reported. Neonatal jaundice occurs more often in East Asian infants than in Caucasian infants. Even if the presence of TA-7 could affect the metabolism of bilirubin in the neonatal period, it does not explain the high incidence of neonatal jaundice in Japanese infants, because the TA-7 allele frequency is very rare in the Japanese population. In the 74 infants in this study, we detected only one homozygous case for TA-7, which happened to be a baby who was in the healthy control group. In the 19 infants with jaundice requiring treatment, we found a TA-7 allele in only one heterozygous case.

In conclusion, our findings indicate that the variant TATA box in the promoter region of the BUGT1 does not contribute to the high incidence of neonatal jaundice in the Japanese population.
Use of laryngeal masks in the resuscitation of a neonate with difficult airway

EDITOR,—Neonates with mandibulo–facial anomalies and respiratory distress present a challenge for neonatologists. We report a newborn boy with severe micrognathia who failed to breathe adequately immediately after birth. Tracheal intubation was unsuccessful, but he was ventilated for several hours using a laryngeal mask.

Case report
The boy was born to a 29 year old primigravida after 39 weeks of gestation. During the pregnancy, absence of the corpus callosum had been noted at 33 weeks of gestation, and genetic amniocentesis had indicated a microdeletion of chromosome 21. No other malformation had been verified. Caesarean section was performed because of intrauterine growth retardation and breech presentation. At birth the boy weighed 2300 g, had multiple contractures of the limbs, bilateral coloboma of the iris, severe mandibular hypoplasia with a small oral orifice and a massive glossoptosis, and a systolic heart murmur. He made feeble attempts to cry, but remained cyanotic and bradycardic despite the jaw thrust manoeuvre and bagging. Oro-tracheal intubation with a 3 mm and a 2 mm tracheal tube were attempts. A lubricated number 1 laryngeal mask was easily put into the right glottic opening. Intubation with a 3 mm man and a 2 mm tracheal tube was unsuccessful. A systolic heart murmur. He had coloboma of the iris, severe mandibular hypoplasia, bilateral growth retardation and breech presentation.

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