The main methods of oxygen administration to infants are reviewed. Some methods are more economical and therefore more useful in developing countries. All the methods have potential complications and therefore need to be carefully supervised.

There are several different methods of non-invasive oxygen administration: head box, facemask, nasal prongs, nasal catheter, and nasopharyngeal catheter (fig 1). Oxygen administration is a routine procedure in the care of ill neonates and infants and therefore it is important to know the efficacy, the risks, and the impact on lung function of the methods used. Arterial oxygen saturation is one of the determinants of oxygen transport. Pulmonary diseases with ventilation-perfusion inequalities lead to diminished arterial oxygen saturation and are amenable to oxygen treatment—that is, administration of an increased fraction of inspired oxygen (FiO₂). In neonates and infants, such diseases include hyaline membrane disease, pneumonia, bronchopulmonary dysplasia, bronchiolitis, and pulmonary oedema.

In developing countries, safe, simple, effective, and inexpensive methods of oxygen administration are favoured.

World wide, acute infections of the lower respiratory tract kill more than 4 million children every year, most of them less than 5 years of age. They are the leading cause of death in that age group and 99% of the deaths occur in developing countries. Oxygen therapy is often life saving. There is a substantial reduction in mortality when oxygen is given to hypoxic patients with very severe pneumonia, as shown for children in Papua New Guinea.1 Oxygen therapy is often life saving. There is a substantial reduction in mortality when oxygen is given to hypoxic patients with very severe pneumonia, as shown for children in Papua New Guinea.1 Oxygen therapy is often life saving. There is a substantial reduction in mortality when oxygen is given to hypoxic patients with very severe pneumonia, as shown for children in Papua New Guinea.1

Of the methods discussed, this is the only one that allows the FiO₂ to be determined precisely. The oxygen concentration should be measured by an oxygen analyser placed near the baby's mouth. There is no increased risk of airway obstruction by mucus and gastric distension. Humidification is not necessary. Headbox oxygen is generally well tolerated, although the limitations placed on mobility are undesirable when prolonged oxygen treatment is required. Furthermore, the enriched oxygen environment is disturbed when feeding or suctioning is required. Giving oxygen by headbox needs relatively high flows to achieve adequate concentrations of oxygen and avoid carbon dioxide accumulation. Carbon dioxide toxicity may occur with low flows of oxygen caused by kinking or disconnection of the oxygen tubing and inappropriate tight seal of the box around the infant’s neck. A gas flow of 2–3 litres/kg/min is necessary to avoid rebreathing of carbon dioxide (J Tibballs and M Hochmann, Royal Children’s Hospital, Melbourne, unpublished).

As with headbox administration, there is a danger of carbon dioxide accumulation if the flow of gas into the facemask is too low. If spontaneous inspiratory flow rates exceed the delivered oxygen flow rate, then there is room air entrainment through the perforations of the mask. The oxygen concentration delivered varies, depending on the infant’s inspiratory flow rate and the oxygen flow into the system. The effective oxygen fraction (hypopharyngeal oxygen fraction, FiO₂) is difficult to predict, but it is rarely above 40%. However, there are no data in newborns and infants. Small children will often refuse to keep a mask over their face. The mask also interferes with feeding.

This kind of oxygen administration is widely used for short periods—for example, after extubation.

**Abbreviations:** FiO₂, inspired oxygen fraction; FiO₂h, hypopharyngeal oxygen fraction; PaO₂, arterial oxygen tension; PEEP, positive end expiratory pressure; CPAP, continuous positive airway pressure

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or when breast feeding an infant who is on headbox oxygen. Owing to the dilutional effects of ambient air, the effective FIO2—that is, the hypopharyngeal FIO2—may be low and is unpredictable. Infants dependent on supplemental oxygen should be given oxygen by nasal catheter when they are fed; this allows a more predictable and stable oxygen delivery.

Nasal cannulae (Fig 1D)
Nasal cannulae, nasal catheters, and nasopharyngeal catheters are more invasive methods of giving oxygen, and questions arise about airway obstruction, gastric distension, the need for humidification, and changes in lung function. Nasal cannulae are a device ending in two short tapered tubes (about 1 cm in length) that are designed to lie just within the nostrils. They are also called nasal prongs. This is the preferred method of home oxygen therapy in infants. Older infants with chronic lung conditions may find it difficult to keep nasal cannulae on, particularly at night. There is no risk of gastric distension, as it is not possible to push them in too far. Humidification is not required with nasal cannulae.

The natural nasal mechanisms are heating and humidifying the inspired gases. There is only a slight risk of airway obstruction by mucus. Weber et al observed complete nasal obstruction in eight out of 62 children (age range seven days to five years) with nasal cannulae. The FIO2 reaching the patient's airway is not easy to determine. Vain et al measured the FIO2, FIO2 is almost identical with the tracheal oxygen concentration, and is therefore a reliable measure of the actual FIO2, the infant is breathing. Ten infants receiving 0.5 or 1 litre/min oxygen through nasal cannulae were examined (table 1). In a recent study, the same oxygen delivery system produced lower FIO2 values with the same flows (table 1). FIO2 was inversely related to respiratory rate and therefore probably minute ventilation. Whether the mouth was open or closed did not affect FIO2. The authors were concerned about possible oxygen toxicity associated with the high FIO2 values they found. However, these levels were measured with exceedingly high oxygen flows not mentioned in any other paper. Fan and Voyles used an indirect method to determine the “true” FIO2. They measured the transcutaneous Po2 for a given nasal cannula flow, and then placed the infants into a headbox to evaluate the FIO2 necessary to reach the same transcutaneous Po2 (table 1).

In infants > 3500 g, 1 litre/min 100% nasal cannula oxygen produced an actual FIO2 of 30%, which is considerably less than the value obtained by Vain et al. However, Fan and Voyles used a different nasal cannula system (a 10 F Hudson oxygen catheter was secured under both nares) and the infants studied were larger. In fact, they found that smaller infants (< 3500 g) required lower flow rates to deliver a given FIO2 (table 1). The 0.5 litre/min value is comparable to the finding of Vain et al in larger infants. Wilson et al observed wide variation in the FIO2 readings for any given infant (however, no measure of distribution is given). Finer et al measured FIO2 in newborn infants receiving low flow nasal cannula oxygen (table 1). They found weight dependent values.

The FIO2 studies show that the actual FIO2 depends on the cannula flow rate, the FIO2 in the cannula gas flow, the relation between prong and nasal diameters, and the patient’s body weight. FIO2 may further depend on minute ventilation and the relative duration of inspiration and expiration. Whether the amount of mouth breathing affects FIO2 is controversial. Sedated infants may have compromised upper airway patency with decreased minute ventilation. Therefore, sedated infants on nasal cannula oxygen may have a lower FIO2 than unsedated infants. On the other hand, nasal cannula flow has been shown to produce positive distending airway pressure, and Hammer et al showed that the application of continuous positive airway pressure (CPAP) in sedated infants improved minute ventilation. Thus, nasal cannula oxygen of sufficient flow may increase the actual FIO2 even in sedated infants. The actual FIO2 may decrease with mouth breathing. Even neonates are not exclusive nose
breathers; they are preferential nose breathers. The high position of the larynx and consequent close apposition of the tongue to the palate contribute to the difficulty the newborn finds in breathing through the mouth. However, they may use the mouth for ventilation, both spontaneously and in response to complete nasal occlusion, and this ability increases with postconceptional age. In healthy, awake neonates, reducing the cross sectional area of nasal dimensions by 50% (by occlusion of one nostril) did not affect tidal flow loops or passive respiratory mechanics.

How should the amount of oxygen applied be regulated: by changing the flow rate or the oxygen concentration, or both? Removing the need for an oxygen blender would definitely simplify oxygen delivery. Finer et al were able to deliver a wide range of FIO2 values to premature and full term newborns using 100% oxygen and a low range flowmeter (25–200 ml/min). Benaron and Benitz analysed the theoretical impact of different weaning strategies on the stability of the actual inspired oxygen concentration. Variability in oxygen delivery is minimal when nasal cannula flow is reduced to the lowest possible flow by using undiluted (100%) oxygen; only then should the cannula oxygen concentration be reduced below 100%. This strategy requires microlitred flowmeters. The data of Vain et al suggest that reducing the FIO2 below 60% has little utility, because of the minimal change in the FIO2 that occurs with a flow change from 1 litre/min to 0.25 litre/min.

When administering supplemental oxygen, the relevant end point is not the FIO2, but the arterial oxygen tension (PaO2) or the arterial oxygen saturation. FIO2 may not be the only determinant of arterial oxygenation. Nasal cannula oxygen application may produce positive end expiratory pressure (PEEP), which by itself is known to increase PaO2. There are three studies measuring PEEP production in infants on nasal cannula oxygen (table 2). There is an increase in end expiratory oesophageal pressure when nasal cannulae are applied, this suggests that PEEP is an indirect measure of pleural pressure.

Thus, nasal catheters require a higher oxygen flow to achieve a given transcutaneous oxygen tension. There is one physiological study of nasal catheters. In 12 infants, the transcutaneous oxygen tension was measured with 1 litre/min nasopharyngeal oxygen (with the tip of the catheter just visible below the soft palate), and again with the catheter withdrawn so that it was only 2.5 cm inside the nostril (nasal catheter). The mean transcutaneous oxygen tension was substantially lower when the tip of the catheter was placed in the nose rather than in the pharynx (mean difference 56 mm Hg, 95% confidence limits 34 to 78 mm Hg). Thus, nasal catheters require a higher oxygen flow to achieve a given transcutaneous oxygen tension.
The PEEP generated by nasal cannulae and nasopharyngeal catheters may be beneficial and a welcome byproduct of this kind of oxygen administration, as long as its magnitude is moderate. CPAP has the potential risk of pneumothorax, pulmonary interstitial emphysema, and pneumopericardium. Pneumothorax may precipitate cerebral haemorrhage in premature infants. Therefore, it is very important to know the magnitude of PEEP applied.

CONCLUSION

There are non-invasive means of oxygen administration (headbox oxygen, holding an oxygen line to the infant's face, and facemask oxygen) and methods involving the insertion of cannulae or catheters for a defined distance into the upper airways (“semi-invasive”). In the latter methods, the impact on lung function has to be taken into account. There is uncontrolled PEEP production, which may be beneficial up to a moderate degree of about 5 cm H₂O by altering the viscoelastic properties of the lung, but may be detrimental if higher. The level of the generated PEEP is positively associated with the oxygen flow, the cannula or catheter diameter, and the distance to which the catheter is inserted into the nasopharyngeal airway, and negatively with the infant's weight. In premature infants (1000 g), up to 1 litre/min given through 1 mm nasal cannulae is safe, and in infants (4–12 kg) up to 1 litre/min given through 2 mm nasal cannulae or 8 F nasopharyngeal catheters is safe with regard to the risk of excessive PEEP production.

“Oxygen treatment is often life saving, but medical oxygen is very expensive for developing countries and therefore methods involving low oxygen flow are economically advantageous.”
Oxygen treatment is often life saving, but medical oxygen is very expensive for developing countries and therefore methods involving low oxygen flow are economically advantageous. Headboxes and facemasks need high flows to achieve adequate oxygenation. The “semi-invasive” methods (cannulae and nasopharyngeal catheters) need less oxygen, with nasopharyngeal catheters being the most economic method. The use of undiluted oxygen is advantageous: there is no need for a blender, and weaning can be achieved by simply decreasing the oxygen flow.

All methods of oxygen administration need supervision by trained personnel to detect and manage complications appropriately. The main complications are hypercarbia with headbox and facemask oxygen, dislodgement with nasal cannulae, and obstruction of the catheter or upper airway, as well as gastric distension, with nasopharyngeal catheters.

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