Weighing alone will not prevent hypernatraemic dehydration

Having recently reviewed the case notes of babies readmitted to hospital in the first 10 days of life (over a one year period), we firmly agree with the views expressed by Laing and Wong.1 The incidence of documented hypernatraemic dehydration secondary to the failure of lactation in Bristol is 1.7 per 1000 live births much higher than that described by Oddie et al in the Northern Region (2.5 per 10 000 live births).2 In addition only 50% of infants readmitted with weight loss of <10% had a plasma sodium concentration measured. The true incidence of hypernatraemic dehydration secondary to lactation problems in Bristol could thus be as high as 3.4 per 1000 live births. Our estimate could be an underestimate. Firstly, our study looked only at infants readmitted within 10 days (Oddie et al looked at infants readmitted up to 1 month of age) and secondly, due to failure to recognise this condition.

Laing and Wong proposed weighing all infants when the Guthrie blood samples are taken, to identify those infants at risk of dehydration.3 We believe that this is too late as in many areas this occurs on days seven or on day 10 with handover of care to the hospital visitor. We have already described a series of babies with hypernatraemic dehydration where all presented to hospital before day seven.4 The case has been made correctly that newborn hypernatremia is due to unsuccessful feeding.5 While we agree that careful examination and observation of the infant while feeding and so forth may identify these babies, we would dispute that this is currently universally possible. Due to midwifery shortages, postnatal wards are short staffed and community midwives are fully stretched, so many women are discharged within a few hours of delivering. If a midwifery home visit does not coincide with a feed, the mother’s assessment of feeding is assumed to be correct (as indeed it usually is): Weighing the baby will reassure most mothers that their baby is following the normal pattern of loss followed by gain. Identification of excessive weight loss should prompt the health professional to examine the baby for evidence of illness and carefully observe breast feeding technique. These mother-baby dyads could then be given additional support and advice in the community and thus successfully establish feeding. In our experience once the baby has become ill and required readmission to hospital the mother is reluctant to continue to attempt to breastfeed.

There continues to be confusion regarding the best way to manage this problem.1 It should be remembered that these babies have normal guts and are suffering from starvation. If the infant is not shocked, rehydration can occur safely using enteral fluids: expressed breast milk or a breast milk substitute. Serum sodium should be measured six hourly initially and the volume of milk altered to ensure a slow return to normality.

We believe that we need to foster a greater awareness of this problem and weigh the babies at risk around day five if we are to prevent tragedies resulting from a common condition affecting otherwise well babies.

D Harding, J Maxham, P Cairns
Neonatal Medicine, Department of Child Health, University of Bristol, Bristol, UK; david.harding@bristol.ac.uk

References
1 Laing IA, Wong M. Hypernatraemia in the first few days: is the incidence rising? Arch Dis Child 2002;87:F158–61.

Hypernatraemic dehydration:
excess sodium is not the cause

I am grateful to Laing and Wong for raising once again the issue of hypernatraemic dehydration in the first few days of life.1 However, I think it is important to remember that hypernatraemic dehydration, like anaemia, is a sign of disease and not a diagnosis in itself. A low haemoglobin concentration in blood is a sign of disease and not a diagnosis. It is commonly caused by hypernatraemic dehydration with diarrhoea. Hypernatraemic dehydration is frequently seen in the elderly and mentally handicapped when their need for basic care, and presumably a regular intake of water, is neglected.6

Hypernatraemic dehydration is a sign of illness not a diagnosis. It is commonly caused by excess water loss or by insufficient water intake. It is either alone or in combination almost never the result of excess sodium intake, which would result in retention of water and an increase in body weight, though this would obviously require intact thirst mechanisms and access to sufficient water.

S Richmond
Sunderland Royal Hospital, Sunderland, UK; Sam.richmond@ncl.ac.uk

References
in the MCA, including systolic, diastolic, and resistance changes are a function of changing vessel calibre. The authors attempted to measure MCA diameter, but because measurements were inaccurate the authors did not attempt to calculate values for MCA blood flow.

Our own studies of cerebral haemodynamics, using near infrared spectrophotometry, supports the view of Evans et al that there are significant changes in cerebral blood flow over the first 36 hours after birth. The demographic details of our cohort were similar to the one studied by Evans et al. Although the patients of mean (SD) gestation 26 (2) weeks and mean birth weight 929 (250) g. We found that a significant increase in cerebral blood flow between days 1 and 2 was accompanied by a significant decrease in cerebral fractional oxygen extraction (FOE). High cerebral FOE may protect the brain from hypoxic-ischaemic injury, a potential consequence of reduced cerebral blood flow.

The results presented by Evans et al give an insight into the complex relationships that exist within a dynamic fluid system. Systemic blood pressure was closely related to MCA mean velocity, but not estimated MCA diameter, thus implying that the blood flow would vary independently of systemic blood pressure because of changes in cerebrovascular resistance. Our own observations have produced similar results. Cerebral FOE, which is expected to increase as cerebral blood flow decreases, is not related to mean arterial blood pressure. There is, however, a significant relationship between cerebral FOE and left ventricular output, which may be a major determinant of central blood flow. This latter finding is in agreement with the observation of Evans et al that superior vena cava flow, also related to central blood flow, was significantly associated with estimated MCA diameter.

Evans et al remind us that velocity is not the same as flow. Their observations, and our own, stress the importance of vascular resistance in mediating the relationship between blood pressure and blood flow. In the sick preterm infant, the presence of an adequate mean arterial blood pressure is often achieved with estimated MCA diameter.

Systemic cerebral blood flow
We read with interest the findings of Evans et al concerning the changes in middle cerebral artery (MCA) haemodynamics over the first two days after birth in preterm infants. Evans et al demonstrated a significant change in several Doppler velocity measures in the MCA, including systolic, diastolic, and mean velocity, pulsatility index and velocity time integral, during days 1 and 2 after birth in a cohort of preterm infants. Blood flow (F), blood pressure (P), and vascular resistance (R) are closely related (F = P/R), and resistance changes are a function of changing vessel calibre. The authors attempted to measure MCA diameter, but because measurements were inaccurate the authors did not attempt to calculate values for MCA blood flow.

We read with interest the findings of Evans et al that there are significant changes in cerebral blood flow over the first 36 hours after birth. The demographic details of our cohort were similar to the one studied by Evans et al. Although the patients of mean (SD) gestation 26 (2) weeks and mean birth weight 929 (250) g. We found that a significant increase in cerebral blood flow between days 1 and 2 was accompanied by a significant decrease in cerebral fractional oxygen extraction (FOE). High cerebral FOE may protect the brain from hypoxic-ischaemic injury, a potential consequence of reduced cerebral blood flow.

The results presented by Evans et al give an insight into the complex relationships that exist within a dynamic fluid system. Systemic blood pressure was closely related to MCA mean velocity, but not estimated MCA diameter, thus implying that the blood flow would vary independently of systemic blood pressure because of changes in cerebrovascular resistance. Our own observations have produced similar results. Cerebral FOE, which is expected to increase as cerebral blood flow decreases, is not related to mean arterial blood pressure. There is, however, a significant relationship between cerebral FOE and left ventricular output, which may be a major determinant of central blood flow. This latter finding is in agreement with the observation of Evans et al that superior vena cava flow, also related to central blood flow, was significantly associated with estimated MCA diameter.

Evans et al remind us that velocity is not the same as flow. Their observations, and our own, stress the importance of vascular resistance in mediating the relationship between blood pressure and blood flow. In the sick preterm infant, the presence of an adequate mean arterial blood pressure is often achieved with estimated MCA diameter.

Evans et al remind us that velocity is not the same as flow. Their observations, and our own, stress the importance of vascular resistance in mediating the relationship between blood pressure and blood flow. In the sick preterm infant, the presence of an adequate mean arterial blood pressure is often achieved with estimated MCA diameter.

Evans et al remind us that velocity is not the same as flow. Their observations, and our own, stress the importance of vascular resistance in mediating the relationship between blood pressure and blood flow. In the sick preterm infant, the presence of an adequate mean arterial blood pressure is often achieved with estimated MCA diameter.

Evans et al remind us that velocity is not the same as flow. Their observations, and our own, stress the importance of vascular resistance in mediating the relationship between blood pressure and blood flow. In the sick preterm infant, the presence of an adequate mean arterial blood pressure is often achieved with estimated MCA diameter.

Evans et al remind us that velocity is not the same as flow. Their observations, and our own, stress the importance of vascular resistance in mediating the relationship between blood pressure and blood flow. In the sick preterm infant, the presence of an adequate mean arterial blood pressure is often achieved with estimated MCA diameter.

Evans et al remind us that velocity is not the same as flow. Their observations, and our own, stress the importance of vascular resistance in mediating the relationship between blood pressure and blood flow. In the sick preterm infant, the presence of an adequate mean arterial blood pressure is often achieved with estimated MCA diameter.
Hyponatraemia as a consequence of serial liquor punctures in preterm infants with a ventricular access device after posthaemorrhagic hydrocephalus

We observed hyponatraemia in several preterm children treated with a ventricular access device (Rickham reservoir) after intraventricular haemorrhage (IVH) and serial liquor puncture to drain liquor. To rule out a connection, we retrospectively investigated the data of all preterm children (23–32 weeks of gestational age) treated at the University Children’s Hospital of Cologne with a ventricular access device during 1996–1999 (n = 16).

Sixteen of 480 preterm infants (3.3%) of less than 1500 g birth weight (430–1500 g) developed an IVH and required treatment with a ventricular access device. The mean gestational age of these children was 27 weeks (range 23–32).

Twelve of them (75%) developed hyponatraemia (< 130 mmol/l). The minimum serum sodium of all patients was 110–136 mmol/l (mean SD 125.8 (6.3) mmol/l). The maximum amount of liquor tapped a day was 3–34 ml (mean 15.6 ml). The resulting daily loss of sodium in the tapped liquor was 0.4–3.7 mmol/kg/day (mean SD 1.98 (0.94) mmol/kg/day). The extent of the hyponatraemia (minimal serum sodium) correlated significantly with the maximum daily sodium loss in liquor (r = 0.78, p < 0.001, fig 1).

Further analysis of the use of drugs—for example, thiazides—did not contribute to this correlation. Two children with hyponatraemia developed general hypotonia with poor feeding; this prompted further diagnostic measures to exclude syndrome of inappropriate antidiuretic hormone (SIADH) or excessive sodium loss in urine. The investigations were negative. Both children showed normal neurology after administration of the sodium lost. No child with hyponatraemia developed other acute neurological symptoms such as seizures.

This is the first report of hyponatraemia as a consequence of serial liquor punctures with a ventricular access device in children. The sodium loss was sometimes as high as the normal sodium requirement per day (3–5 mmol/kg/day).

Hyponatraemia in children caused by the use of a ventricular access device should be managed carefully and the sodium replaced promptly. Loss of sodium by serial liquor tapping must be taken into the differential diagnosis of hyponatraemia in preterm infants.

K Tenbrock, A Kriss, B Roth
Department of Neonatology and Pediatric Intensive Care, University Children’s Hospital of Cologne, Cologne, Germany

B Speder
Neurosurgical Department, University Hospital of Cologne

References

Use of animal surfactant: should we seek consent?

Animal derived surfactants such as Curosurf (porcine) and Survanta (bovine) are the commonly used surfactants in the United Kingdom. Involvement in a trial of a new artificial surfactant, and the specific information on the origins of the surfactant in the patient information leaflet led us to review our practice. Two families declined to participate in the trial. A Hindu family wished to avoid use of Survanta, as cows are considered sacred in Hindu religion. A Moslem family preferred to avoid the perception that the medical profession has a patronising attitude.

We hope to generate a discussion to see if a consensus can be evolved.

R Adappa, R Benson
Department of Paediatrics, Ysbyty Gwynedd, Bangor, N Wales, UK

S Oddle, J Wylie
Neonatal Intensive Care Unit, James Cook University Hospital, Middlesbrough, UK

Correspondence to: Dr Adappa; roshanadappa@aol.com

Intravenous propacetamol overdose in a term newborn

Following a prescribing error, a term female infant was given two intravenous doses of 900 mg propacetamol (307 mg/kg/dose) at 6 hour intervals, which is 10 times the routine dose used in our unit (120 mg/kg/day, 30 mg/kg/dose). When the error was noted, immediately after the second dose, the plasma paracetamol level was 163.8 mg/l. N-Acetylcysteine was given as follows: 150 mg/kg (450 mg) after 15 minutes, 50 mg/kg (145 mg) after four hours, and 100 mg/kg (290 mg) after 16 hours. Plasma paracetamol levels were checked: 119.9 mg/l five hours later, 61.4 mg/l 11 hours later, 28.8 mg/l 16 hours later, and finally 1 mg/l 24 hours after the second dose (fig 1). Liver function and clotting factors were normal. The infant was discharged on day 7.

Paracetamol poisoning in newborn babies is usually due to the maternal absorption of high doses of the drug just before birth or oral absorption of an inappropriate dose. Reports of propacetamol overdose are unusual, and so far the overdose has only been by intramuscular injection. As far as we know, this is the first report of intravenous propacetamol poisoning in a newborn. This reason may be the rare use of this drug during the neonatal period, the pharmacokinetics having been

References
published in only one study for this stage of life. However, as with other routes of administration described in the literature, no adverse effects were seen in this case. The administration of N-acetylcysteine following guidelines given for older patients proved efficient. The elimination of the drug seems to be linear. Although drug overdose should be carefully avoided, intravenous propacetamol is probably safe in term newborn babies.

A de la Pintière, A Beuchée, P E Bétrémieux
Unité de réanimation néonatale et pédiatrique, Pavillon Lechartier CHU Pontchaillou, Rennes 35033, France; pierre.betremieux@chu-rennes.fr

References

Endotracheal tube fixation in neonates
A stitch in time saves nine. But not all neonatal units believe in this saying and use different methods to secure oral endotracheal tubes in neonates who require ventilatory support. Success in stabilising a premature infant is best achieved by least intervention and good ventilatory support. A stable oral endotracheal tube will help. A naso-oral endotracheal tube is extremely easy to stabilise; however, stabilisation is not routinely performed in the United Kingdom.

Three commonly used methods are: (a) stitching the tube to a plastic flange; (b) fixing a premeasured and cut tube in a flange with adhesive tape; (c) fixing a premeasured and cut tube into a tight fitting flange. In all three methods, the tube is secured by tying it to the baby’s hat.

Normally, weight or foot length is used to determine endotracheal tube size, and this is quite reliable. However, head movement, suctioning, and patient care can all cause instability and displacement of the tube. If the tube is too short, there will be ineffective ventilation. If the tube is too long, it may collapse resulting in selective ventilation. A precut tube is difficult to manipulate if the positioning is not satisfactory. This is not a major problem in a stitched tube. There are pros and cons to each method.

There are no comparative studies from the United Kingdom to evaluate the benefits and disadvantages of each method. A search through the databases found no randomised trials comparing various techniques, except one study which compared an umbilical clamp with the routine fixing method. Accidental extubation or unsatisfactory positioning of the tube may influence the reintubation rate. Securing and properly stabilising an endotracheal tube can solve this problem to a large extent.

A prospective randomised trial evaluating each method against reintubation criteria will help neonatal units to adopt the correct policy for their own situation.

V A Pai
Southmead Hospital, Bristol, UK
B V Pai
Royal United Hospital, Bath, UK; binapai@hotmail.com

References