Neonatologists are not always directly involved in the intensive care of neonates as surgical patients. In my own case this has led to a slightly blinkered approach. I am very familiar with perinatal stabilisation of problems such as chylothorax, subcutaneous stenosis, or necrotising enterocolitis and describe the authors' perspective on management. There are numerous photographs, radiographs, and drawings in nice balance with the text. Fascinating drawings, intended to complement the “comprehensive description of operative techniques” left me wondering that such complicated operations could be understood as described. The authors are drawn from all over the world, but the book’s style remains uniformly European.

The book begins with a series of chapters dedicated to general and theoretical aspects of the care of these high-risk infants. These areas of overlap with standard neonatal texts are very variable and, from my perspective, also very interesting. Some could have been more up to date. It was also interesting for example to see a chapter on neonatal transport written by two paediatric surgeons rather than by neonatologists.

Some overlap is inevitable in a book like this. However, I would have preferred, for example, that there was more embryology in each surgical chapter or a more comprehensive introductory chapter. A well written chapter on ethics, from a purely North American perspective, occupies eight pages, which is also the space given to parenteral nutrition. The five sides dedicated to respiratory management of the newborn patient were obtained in 35 patients: mean (SD) was 147 (6.7) mmol/l, and in 14 (40%) the levels were over 50% of children in China and Tibet have severe iodine deficiency.

The chapters on surgical problems are the book’s strongest area. We have found the book valuable in furthering our understanding of the problems we see on a day to day basis. Many of the lesions in question are relatively rare, which makes the superspecialist multiauthour approach most valuable. The inclusion of problems sometimes dealt with by neurosurgeons and plastic surgery specialists may be an especially attractive volume. The occasional chapter seemed to focus too heavily on the authors’ own experience without consideration for the variety of techniques in use. I am glad to say that this book is the one to plug the gaps in my knowledge. I would therefore recommend this book to fellow paediatricians, much as I would encourage surgeons and neonatologists to further develop collaboration in practice and in training.

With 97 chapters, typically under 10 pages each, this book certainly has breadth of coverage. Chapters typically deal with a problem such as chylothorax, subcutaneous stenosis, or necrotising enterocolitis and describe the authors’ perspective on management. There are numerous photographs, radiographs, and drawings in nice balance with the text. Fascinating drawings, intended to complement the “comprehensive description of operative techniques” left me wondering that such complicated operations could be understood as described. The authors are drawn from all over the world, but the book’s style remains uniformly European.

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Increasing incidence of moderate neonatal hyperbilirubinemia in Wirral
Severe neonatal jaundice and bilirubin encephalopathy have been reported with increasing frequency from North America and Europe. There are no published reports of similar trends in Britain. We therefore examined trends in moderate neonatal hyperbilirubinemia in Wirral Hospital between 1991 and 2001. Neonates of >34 weeks gestation with a serum bilirubin of >340 μmol/l were identified from the laboratory database. Trends in hyperbilirubinemia were analysed using the χ² test for trend. A total of 184 infants were identified; 122 presented before initial discharge, and 62 were readmitted. Median (interquartile range) gestational age was 38 (37–39) weeks, and 6% of affected infants were breast fed. The incidence of moderate jaundice increased from 2.4/1000 live births in 1991 to 5.3/1000 in 2001 (p < 0.0001). Despite a progressive fall in annual births, readmissions for jaundice increased from seven in the first six years of study to 35 in the second five years (p < 0.0001). Five infants needed exchange transfusion; all had haemolytic disease. All were identified before initial discharge. No infants developed bilirubin encephalopathy, and none died.

Ours is the only report of recent trends in neonatal jaundice in Britain. Whether our experience is representative is not known, nor is the national incidence of bilirubin encephalopathy. These questions may be answered by this continuing study, supported by the British Paediatric Surveillance Unit, of severe neonatal jaundice.

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Use of abbreviations in daily progress notes
Errors in medication and documentation are reported. These errors, no matter how minor, could have grave consequences for the patient, especially in the paediatric population. One of the major threats to small neonates. Recently, Carroll et al described problems in residents’ progress notes in a neonatal intensive care unit. Being the busiest centre in the country, managing the great majority of seriously sick neonates, we are at a very high risk of these errors. In view of this and as a screening audit, we looked at a few progress notes written on our inpatient neonates. One example of a progress note, written by a junior doctor, stated: ‘Prem 32 WOG, F&G: RDS, IVH II, S/P SVT, Stable on RA, TPR normal, PU, BO, Chest, CVS & abdomen: NAD’. This excessive and inappropriate use of abbreviations is alarming and disturbing. The abbreviations denoted the following (in order of citation): weeks of gestation, feeder and grower, respiratory distress syndrome, intraventricular grade 2 haemorrhage, status post supratentorial tumour, total protein, right heart rate, BP (blood pressure), PA (per abdomen), O/E (on examination), NGT (nasogastric tube), UE1 (urea and electrolyte 1), BGA (blood gas analysis), BBA (born before arrival), TPN (total parental nutrition), SLS (standard lipid solution), STS (standard TPN solution), D/w (discussed with), SBR (serum bilirubin), CTG (cardiotocograph), IUGR (intrauterine growth restriction), RRT (Blalock-Taussig shunt), TAT (trans-anastomotic tube), IVF (intravenous fluid or in vitro fertilisation), POD (postoperative day), ASD (atrial septum defect), VSD (ventricular septum defect), PDA (patent ductus arteriosus), TR (tricuspid regurgitation), L-R shunt (left to right shunt), TOF (tetrology of Fallot), CRT (capillary refill time). One interesting note that needs separate mention was ‘Plan is to start ABs after ARC’ (ABs, antibiotics; ARC, aerobac blood culture).

We noted a high frequency of the use of abbreviations in our neonatal unit. This was a single day observation; we would expect much more variability within our unit. Fortunately, none of the abbreviations had resulted in erroneous interpretation, as most of the staff were used to them. However, this does not indicate that it is all right to use abbreviations. Standard abbreviations, such as VSD (ventricular septal defect) and PDA (patent ductus arteriosus), are acceptable, whereas others are not.

Documentation errors have been reported to be an increasing problem in day to day care of patients. A recent report described the same negligence in documentation by residents. Carroll et al found discrepancies in the daily progress notes written by a resident doctor in the neonatal intensive care unit. They also found that notes often contained inaccurate information and lacked pertinent information. We looked further into the situation and found extensive use of abbreviations in progress notes.

Our observation is not unique and requires rectification. The solution could be to standardise or eliminate the use of abbreviations in the unit. Total elimination would be difficult, as many of the abbreviations are acceptable. Thus, the use of unacceptable abbreviations should be discouraged. New medical officers should be given brief instruction on the writing of appropriate progress notes. An alternative is to use the electronic information system for all medical transcription including progress notes, as described elsewhere.

In conclusion, care of neonates requires good documentation of day to day progress. The use of unacceptable abbreviations should be discouraged. A follow up audit is warranted to look further into the effect and success of our recommendations.

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Use of nasal continuous positive airway pressure during neonatal transfer
Within neonatal intensive care units, nasal continuous positive airway pressure (nCPAP)
provides a means of respiratory support in a variety of acute and chronic clinical situations. We have used it as a means of respiratory support during neonatal transfer and describe our experience below.

nCPAP was provided by the Infant Flow Driver (Electro Medical Equipment Ltd, Brighton, Sussex, UK). This was clamped on to the vertical frame of the transport incubator, and a modified ventilation circuit, designed by the medical physics department of the Princess Royal Maternity, connected the Infant Flow Driver to the infant via short nasal prongs (Electro Medical Equipment Ltd). All transfers were transferred by road in the West of Scotland Region dedicated neonatal ambulance. This ambulance provided an oxygen and air supply of 4000 litres each, and AC power from a petrol generator.

Over a one year period from April 2002 until April 2003 there were seven nCPAP transfers involving six infants. The median gestational age at birth was 29 weeks (range 26–32) and the median age at transfer was 25 days (range 5 hours to 91 days). These included infants with complex congenital abnormalities requiring specialist treatment and those returning to their base hospital. The median transfer time was 45 minutes (range 30–60). No major problems were encountered during transfer. All transfers using nCPAP were discussed in advance with a senior neonatologist experienced in neonatal transport.

We have shown in a small and carefully selected cohort of infants that transfer with nCPAP support is feasible and safe. Our infants, with one exception, had been stable on nCPAP for some time before transfer. Further studies are required to explore whether this form of respiratory support has a role in the transfer of neonates with acute respiratory distress syndrome who are stable on nCPAP, and who would currently be intubated only because of the need for transfer.

Correct attachment of the nCPAP driver to the transport incubator system is vital. Further modifications are being engineered to our transport incubator system to comply with regulations ensuring safety in crash situations.

Even with our confidence in the use of nCPAP for selected clinical situations in transport, we would still strongly recommend that intubation remains the first choice for airway management during neonatal transfer.

What is the normal range of blood glucose concentration in healthy term newborns?

The report by Dr Nicholl on ‘normal blood glucose concentrations in healthy term newborns’ raises the interesting and important question of how normoglycaemia in newborns can be defined. In a comprehensive review of the literature in 1997, an expert panel of the World Health Organization concluded that there are numerous approaches to defining normoglycaemia, including the statistical approach (which was taken by Dr Nicholl), the metabolic approach (what is the concentration of blood glucose at which normal cell homocostasis is maintained?), the neurophysiological approach (below what concentration of blood glucose does impairment of neurological functions occur?), and, perhaps most importantly, the neurodevelopmental approach (does a relation exist between neonatal blood glucose concentrations and the neurodevelopmental outcome of children years later?)?

These different approaches towards definition of normoglycaemia contribute to the controversy that surrounds this issue. Other factors that influence newborn blood glucose concentrations, even in healthy term newborns, are perinatal complications, mode of delivery, and feeding behaviour. It appears that there is very little solid evidence on which judgment of neonatal blood glucose concentrations can be based. Follow up studies looking at neurodevelopmental outcome of neonatal “hypoglycaemia” (and its treatment) in healthy term infants of various delivery modes and birth weights are urgently needed.

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References

Gastric perforation and transillumination

We read with interest the article of Farrugia and colleagues about neonatal gastrointestinal perforation. However, there was no mention of:

- Isolated gastric perforation as a cause of neonatal gut perforation, or
- Transillumination as a simple diagnostic tool of pneumoperitoneum.

We highlight these two points relating to a recent case. A 29 week gestation baby girl was born by vaginal delivery. She initially required conventional ventilation for her lung disease. An umbilical arterial catheter was inserted but removed after a few hours due to diskiness of the toes. On day 2 she was evaluated and nCPAP was tried. After a few hours, her condition deteriorated and she returned to conventional ventilation. On day 4, she was started on enteral feeding, using small volumes of breast milk, but had mild abdominal distension and some aspirates. Feeding was stopped. Her abdomen deteriorated and she had persistent metabolic acidosis. Transillumination of her abdomen was positive (fig 1) for pneumoperitoneum and was confirmed by abdominal x ray examination (fig 2). At laparotomy, two small gastric perforations were identified with local areas of infarction. These were oversewn, with excellent results.

Neonatal gastric perforation is unusual but serious. Various causative factors, including prematurity and nCPAP, have been suggested. Both of these were present in our case. It is also possible that emboli from the umbilical catheter led to small areas of infarction of the stomach wall.

Transillumination is a quick and easy technique for diagnosing pneumoperitoneum, and obviates the need for frequent radiographs.

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References
Renal fungal ball

Preterm infants are prone to fungal infections because of immaturity of their host defence systems (immunology and skin). Other risk factors include multiple antibiotic therapy, prolonged use of umbilical or percutaneous catheters, total parenteral nutrition, colonisation and/or past mucocutaneous candidiasis, low birth weight, endotracheal tube placement, and congenital malformation.

Common sites for invasive candidiasis are the renal system, eyes, brain, and heart. Diagnostic tests should include blood and urine cultures, renal ultrasound, ophthalmological assessment, cardiac ultrasound, and examination of cerebrospinal fluid.

Candiduria may indicate colonisation, but the presence of other clinical signs increases the risk of invasive candidiasis. Fungal ball is the commonest presentation of renal fungal disease.

Clinical presentation may vary and can be obstructive, or non-obstructive, with renal failure.

A baby born at 28 weeks gestation was known to be colonised with Candida spp in the first weeks of life. The mother had declined routine antenatal care. The baby was ventilator dependent, with umbilical lines and received multiple broad spectrum antibiotics for possible bacterial sepsis.

After one month the baby developed thrombocytopenia and renal impairment. A renal ultrasound confirmed the presence of a solitary kidney with an echogenic mass.

Limited postmortem examination revealed multiple abscesses in the renal parenchyma, which grew Candida albicans only.

Invasive fungal infections in very low birthweight babies are currently the subject of a BPSU study (http://bpsu.inopsu.com/current.htm#Invasive).

REFERENCE


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