

Table 1 Serum alkaline phosphatase activity and calcium and phosphate concentrations according to vitamin D status

Vitamin D status	No	GA (weeks)	CGA (weeks)	ALP (U/l)	Ca ²⁺ (mmol/l)	Phosphate (mmol/l)
Deficiency (<50 nmol/l)	16	27.4 (25–29)	33.3 (28–43.1)	1519 (1050–2653)	2.56 (2.13–2.67)	1.9 (0.95–2.51)
Mild deficiency (50–69 nmol/l)	4	26.9 (26–30)	34.4 (31.3–47.6)	1256 (1048–1628)	2.67 (2.54–2.75)	2.42 (1.58–2.55)
Normal (≥70 nmol/l)	3	27.6 (26–28)	35.1 (31–38)	1196 (1089–1334)	2.68 (2.64–2.72)	2.46 (2.25–2.51)

Values are mean (range).

CGA, corrected gestational age at vitamin D sampling; GA, gestational age at birth.

treatment of vitamin D deficiency is vital. ALP, calcium and phosphate are not adequate surrogates for OP and/or vitamin D deficiency. In addition, vitamin D supplementation in infancy may protect against type I diabetes mellitus and is involved in immunomodulation.⁴ Recently, the association between vitamin D deficiency and infantile heart failure has also been reported.⁵ Sixty-four percent of infants in whom vitamin D was determined were markedly deficient (<50 nmol/l), and 87% had some degree of deficiency (<70 nmol/l). We suggest that vitamin D concentrations should be assessed in all VLBW infants, as vitamin D deficiency is a readily treatable cause of bone disease.

R McCarthy,¹ N McCallion,¹ G Harrison,¹ E J Molloy^{1,2}

¹ Department of Neonatology, National Maternity Hospital, Dublin, Ireland; ² UCD School of Medicine and Medical Science, Dublin, Ireland

Correspondence to: Dr E Molloy, Department of Neonatology, National Maternity Hospital, Holles Street, Dublin 2, Ireland; emolloy@nmh.ie

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Infection control during administration of parenteral nutrition in preterm babies

Total parenteral nutrition (TPN) is standard practice for preterm babies in modern

neonatal intensive care units.¹ Although more difficult to site, peripherally inserted percutaneous central venous catheters need to be replaced less frequently than peripheral cannulae and therefore have been shown to reduce interruptions in nutrition.² The guidelines of the Centers for Disease Control and Prevention on prevention of infection related to peripherally inserted percutaneous central venous catheters³ recommends the use of “maximal sterile barrier precautions” (use of cap, mask, sterile gown, sterile gloves and large sterile drape) for the insertion of the line, but it acknowledges that the efficacy of these recommendations has not been studied. Furthermore, the guidelines do not stipulate if sterile barrier precautions should also be applied during subsequent changing of bags of parenteral nutrition. We observed an increase in the incidence of bacteraemia in premature babies from January to April 2006 in our neonatal intensive care unit in North Queensland, Australia. An infection control guideline was introduced on May 2006 in which TPN bags were changed every 48 h, with the use of maximal sterile barrier precautions. This practice was, however, expensive and time consuming. Retrospectively, we investigated the effect of the new infection control technique in reducing the bacteraemia rate. The study period was divided into two 12-month epochs, before and after implementation of the changes. Any premature baby admitted during the study period who received TPN via a peripheral long line was included in the study. Blood culture results at birth and before the insertion of the long line were excluded from analysis. Analysis revealed that the percentage of babies receiving TPN who subsequently developed bacteraemia was higher in the pre-intervention group than in the post-intervention group (odds ratio (OR) 2.13; 95% CI 0.93 to 4.90). Mortality was 9.4% in the pre-intervention group compared with 2.6% in the post-intervention group (OR 3.67; 95% CI 0.93 to 20.9). Multivariate logistic regression showed that bacteraemia was associated with gestation (OR 0.65; 95% CI 0.44 to 0.97) and TPN use (OR 4.17; 95% CI 1.37 to 12.7) in the pre-intervention group. We

concluded that the new regimen reduced bacteraemia and mortality, although the study was not a randomised and controlled trial and could not account for unmeasured or unknown confounders.

Y Kandasamy

Correspondence to: Dr Y Kandasamy, Department of Neonatology, Townsville Hospital, 100 Angus Smith Drive, Douglas, Queensland 4814, Australia; Yoga_Kandasamy@health.qld.gov.au

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CORRECTIONS

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O Plan, G Cambonie, E Barbotte, *et al*. Continuous-infusion vancomycin therapy for preterm neonates with suspected or documented Gram-positive infections: a new dosage schedule (*Arch Dis Child Fetal Neonatal Ed* 2008;**93**:F418–21). On page F419 of this article (2nd paragraph, 6th line) the infusion concentration should be “5 mg/ml” (not “5 mg/l” as published).

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C F Hagmann, N J Robertson, V R Sams, *et al*. Postmortem magnetic resonance imaging as an adjunct to perinatal autopsy for renal-tract abnormalities (*Arch Dis Child Fetal Neonatal Ed* 2007;**92**:F215–18). This article was originally published with an incorrect digital object identifier (doi). It has been updated with the correct doi: 10.1136/adc.2005.092387. We apologise for any inconvenience caused.