Early discharge of low birthweight infants

Sir,

The paper by Lefebvre et al.,1 whose conclusions are largely in agreement with our recently reported experiences,2 is another nail in the coffin for those who wish these babies to reach a certain empirically guessed at weight before being allowed home. It is sad to find that the message is still slow to percolate into many units.

The key to the success of being able to send babies home earlier than has traditionally been practised is the early and, thereafter, the regular involvement of mothers and fathers with their baby in order to help them form a ‘bond’ which should otherwise have developed had physical separation not been enforced by preterm birth. In the intensive care area this involvement includes gently touching the baby, cleaning its mouth, changing napkins, tube feeding etc, even if the baby is being ventilated. Later, as the baby passes through high dependency to special care, the parents must be encouraged to spend as much time as possible in bathing, feeding and making up feeds, taking for a walk outside the hospital in a pram (weather permitting), choosing clothes for the day etc. By the time our discharge criteria are fulfilled the parents are already looking after their baby who is known to them and the fact that he is still often very small seems no longer important. Going home then becomes a logical sequel, irrespective of age or weight. If possible the mother should be encouraged to stay a couple of nights in a room near the neonatal unit to have complete charge of her baby with the support of staff near at hand for any queries that might arise. (Regrettably all too many hospitals still have no such provision.) We lay particular emphasis on the door being always open to babies who are discharged. Parents are encouraged to phone if they have queries or problems, and to visit at any time. The follow-up clinic is an integral part of our support system since it is organised entirely by the neonatal unit nursing and medical staff.

If early separation of babies from their mothers is unavoidable due to preterm delivery at least early reuniting with the family is possible. Provided there is good liaison between the neonatal unit and the health visitor there is no significant increase in the community work load. The family will save money on travel and suffer much less the not inconsiderable inconvenience which so often arises in visiting babies in hospital. Fewer nursing hours will be spent on small but otherwise healthy babies, affording more time for the care of those who are sick. Prolonged and unnecessary separation after birth might also be potentially harmful for the psychological well-being of parents and baby.3 It might also contribute to the risks of non-accidental injury, a problem to which preterm infants who are admitted to a neonatal unit seem to be especially vulnerable.4 A more critical appraisal of discharge policies might go some way to minimising these hazards.

References


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Prevention of infective endocarditis

Sir,

Prompted by Dr Scott’s recommendations on the use of amoxycillin to prevent bacterial endocarditis,1 we carried out a small study to assess the blood levels attained in children; we could find no published data on this aspect. Twelve fasting children with heart anomalies, aged 2–14 years and weighing 11–62 kg, were given amoxycillin by mouth 11–3 hours before operation under general anaesthesia, mainly for dental extractions. One child was premedicated with Valerargan, the others had no premedication. Five children aged 9–14 years received 3 g amoxycillin, and 7 children aged 4–9 years received 1.5 g amoxycillin. In 10 of the 12 children serum amoxycillin levels at the time of operation ranged from 14·4 to 64·0 mg/l and 4–6 hours postoperatively ranged from 8·9 to 37·0 mg/l. Two children aged 2 and 13 years had serum amoxycillin levels of 4·8 and 5·6 mg/l at the time of operation, and 5·0 and 4·4 mg/l about 6 hours postoperatively.

For at least 4 hours postoperatively all the children had serum amoxycillin levels well above the minimum bactericidal concentration of Streptococcus viridans of 0·12 mg/l or less, described by Shanson et al.5 We were unable to check that adequate serum amoxycillin levels persisted for 6–9 hours postoperatively,4 but the serum amoxycillin levels in adults reported by Shanson et al.5 strongly suggest that the 6–9 hour levels in our children would have been adequate.

References

How fast can babies breathe?

Sir,
In reply to Dr McNicholl, we have recorded and videotaped respirations sustained at over 200/minute in Joubert’s syndrome: with the video technique the micro-

phone easily picks up the sound of the panting. The vest method is also satisfactory, giving a continuous record of total lung volume. As a rider, we would suggest that unexplained bouts of extreme tachypnoea with high
to feed. A Continuous record on ultrasonic scan should prompt an ERG to exclude Leber’s congenital retinal amaurosis; we have seen 4 cases since the report of Tomita et al.

References
1 McNicholl B. How fast can babies breathe? Arch Dis Child 1982; 57: 481.

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Book reviews


Human dysmorphology and genetics has evolved from certain basic discoveries made during the last 25 years. In 1956 Tjio and Levan correctly postulated that the human karyotype contained 46 chromosomes and in the early 1970s Caspersson and others devised banding techniques so that the individual chromosomes and their bands or genetic markers could be mapped accurately. After this became possible, and inevitable, that Jean de Grouchy and Catherine Turleau should compile their famous Atlas of chromosomal anomalies. The first edition appeared in 1977 and now the second edition is with us. Although written in French there is an English language edition available in the USA (Wiley, New York).

This large volume contains about 900 illustrations, mainly of good quality. A schematic diagram of each chromosome is compared with photomicrographs using various staining techniques. The value of this is obvious. Syndromes of monosomy, trisomy, deletion, and ring formation are presented in detail with a number of key references. Morphological details, broken down into body systems, are given so that the appearance of each phenotype can be obtained and compared with the relevant photographs.

Cytogenetic details are given and, where appropriate, details of dermatoglyphic analysis. An appendix of cytogenetic techniques including staining, fluorescence, the preparation of buccal smears and chromosome nomenclature completes this remarkable work. This is a major compilation essential for every paediatric assessment unit is unquestioned.

MA SALMON

Cautionary notice

A Bedtime Story

Once upon a time there was a Year book of pediatrics. It was small and contained short abstracts of articles which had interested a paediatrician called Gellis. His choice was personal and sometimes idiosyncratic but he was interested in all sorts of articles that interested many other paediatricians. He was a sensible man who recognised that true knowledge was only written in the English language, and that the trust was published in American journals. The text was illustrated with pictures of children, clinical signs, and radiographs. At the end of some of the abstracts he wrote brief, persona notes which combined sense, stimulation and fun. At the end of his book was a list of the authors of the original papers which had been abstracted. Eminent paediatricians throughout the land consulted that list to find out if they had written anything interesting in the previous year. It was compulsive reading and kept me from going to bed.

For 1982 there is still a Year book of pediatrics.* It is nearly 500 pages long and has two editors. The abstracts are carefully prepared and, quite often, contain the actual figures and graphs from the original papers. The comments which follow the abstracts are written by a variety of eminent people, many of whom enjoy writing comments that are longer than the abstract to which they refer. Impertinent jokes and reminiscences have little place in the new order. There is no author index at the back to browse through. But there is a list of 50 true/false questions about the contents of the book so that the reader can check whether he has been reading it awake or asleep. That worries me because, somehow or other, I seem to be in bed.

Prevention of infective endocarditis.

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Arch Dis Child 1983 58: 79-80
doi: 10.1136/adc.58.1.79-a

Updated information and services can be found at:
http://adc.bmj.com/content/58/1/79.2.citation

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