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Hypernatraemic dehydration and infant mortality

Sir,

Discussion of the most appropriate treatment of hypernatraemic dehydration in infancy (Bannister, Matin-Siddiqi, and Hatcher, 1975), together with reports on the connexion between that condition and sudden death in infancy (Emery, Swift, and Worthy, 1974), has led us to report our experience at the Royal Liverpool Children's Hospital in 1972 and 1973.

During this period 4 of 14 children admitted with hypernatraemic dehydration died, a mortality of 28%. All 4 deaths were in infants under 6 months of age. 3 of the babies who died (Cases 1, 2, and 3) were admitted *in extremis* with circulatory failure and severe electrolyte

and acid-base disturbance and with a very brief history of illness (see Table). It can be speculated therefore as to how much longer these infants who did not show an effective response to resuscitation, could have remained at home before dying 'unexpectedly'.

Not only is hypernatraemic dehydration a significant cause of sudden death in infancy, but the point must also be made that as much can be done to prevent as to treat the condition. There was evidence that 11 of the 14 cases, including all 4 infants who died, consistently received feeds containing excessive solute and calories. None of the 14 had been breast fed.

We therefore add our plea to that of other contributors to your journal for more ready recognition of those factors in infant nutrition, particularly hyperosmolar feeding, which lead to hypernatraemic dehydration and thus contribute appreciably to mortality in early childhood.

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TABLE

Case no.	Sex	Age (w)	Duration of illness before admission (h)	Initial serum sodium (mEq/l)	Initial blood urea (mg/dl)	Initial base deficit (mEq/l)
1	F	5	24-36	184	200	15
2	F	6	12	169	189	Not done
3	F	12	<6	153	57	20
4	M	22	120	155	110	6