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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.

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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 1½-3 hours before operation under general anaesthesia, mainly for dental extractions. One child was premedicated with Vallergran, 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.*² We were unable to check that adequate serum amoxycillin levels persisted for 6-9 hours postoperatively,^{3 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.

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