Fig. 1 Daily enteral calcium intake of 8 neonatal survivors of <1000 g birthweight developing rickets (○) compared to 7 neonatal survivors of <1000 g birthweight not developing rickets (■). The in utero accumulation rate of Shaw⁵ is also shown (●).

Fig. 2 Daily enteral phosphorus intake of 8 neonatal survivors of <1000 g birthweight developing rickets (○) compared to 7 neonatal survivors of <1000 g birthweight not developing rickets (■). The in utero accumulation rate of Shaw⁵ is also shown (●).

- ² Day GM, Chance GW, Radde IC, Reilly BJ, Parks E, Sheepers J. Growth and mineral metabolism in very low birth weight infants. II Effects of calcium supplementation on growth and divalent cations. *Pediatr Res* 1975; **9**: 568-75.
- ³ Steichen JJ, Gratton TL, Tsang RC. Osteopenia of prematurity: the cause and possible treatment. *J Pediatr* 1980; **96**: 528-34.
- ⁴ Rowe JC, Wood DH, Rowe DW, Raisz LG. Nutritional hypophosphataemic rickets in a premature infant fed breast milk. *New Engl J Med* 1979; **300**: 293-86.
- ⁵ Shaw JCL. Evidence for defective skeletal mineralization in low birth weight infants. The absorption of calcium and fats. *Pediatrics* 1976; **57**: 16-25.

Haemophilus influenzae infection in the newborn

Sir,

In recent months we have encountered 2 newborn infants with congenital *Haemophilus influenzae* infection. The first was a 32 week preterm infant (birthweight 1.5 kg) delivered vaginally, who developed respiratory symptoms shortly after birth. The chest x-ray film showed right lower lobe consolidation. *H influenzae* was isolated from the blood culture, gastric aspirate, and superficial swabs. The infant made a satisfactory recovery on intravenous ampicillin and gentamicin.

The second infant was delivered vaginally at term (birthweight 2.8 kg). She exhibited fetal distress during labour. She was acutely ill from birth, being tachypnoeic, acidotic, and shocked. *H influenzae* type B was isolated from the blood cultures and gastric aspirate. Despite treatment with antibiotics, assisted ventilation, and peritoneal dialysis for acute renal failure she died at age 3 days.

Although we had not previously seen congenital *H influenzae* infection at our unit, a series of 9 cases have been reported in the United States.¹ The severity of the infection is emphasised by the high mortality in that report. After our recent experience we think that the possibility of *H influenzae* should be considered when selecting an antibiotic regimen for the infected newborn before obtaining culture reports. We would be interested to know if other units are experiencing problems with this organism.

Reference

- ¹ Lilien LD, Yeh, TF, Novak GM, Jacobs NM. Early onset haemophilus sepsis in newborn infants: clinical, roentgenographic and pathologic features. *Pediatrics* 1978; **62**: 299-303.

References

- ¹ McIntosh N, Livesey A, Brooke OG. Plasma 25 hydroxy-vitamin D and rickets in infants of extremely low birth-weight. *Arch Dis Child* 1982; **57**: 848-50.

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