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 Shaw 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 Shaw is also shown (●).

References


Correspondence 477


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 actue 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


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