The late WS Craig records the anatomical site of bleeding in 345 infants seen over a period of 11 years—a considerable clerical task made easier today by the use of computers and provided the initial observations and recordings are accurate! The most common site was gastrointestinal (155), followed by cutaneous and subcutaneous (96), cord/umbilicus (26), and haematuria (23). There were fewer than 20 cases each of superficial trauma, haemoptosis, buccosalphyngeal bleeding, and after circumcision. Seventy-four babies had bleeding from more than one site, five of which bled from three sites.

The principal interest in this paper today is the reference made to the routine use of vitamin K. Despite enthusiastic claims by others of the ‘virtual disappearance of haemorrhagic disease’ with this treatment Professor Craig remained unconvinced. He found evidence of coagulation defect in only 24 of his 345 cases and among the 52 deaths haemorrhage was the primary cause in only five.

He agreed with Wintrobe (1951) in thinking that the condition was self-limited and argued that:

‘If coagulation defect is the only aetiological operating factor it is difficult to understand why simultaneous bleedings in multiple sites should not be of common occurrence (Quick, 1942).’

He finishes with the comment:

‘Reasons are advanced for questioning the value of vitamin K therapy in the prophylactic and curative treatment of primary intrinsic gastrointestinal haemorrhage of the newborn.’

Today The debate about giving every newborn baby vitamin K continues. This may in part be due to the varying incidence and severity of vitamin K dependent haemorrhage from place to place in the United Kingdom. My personal experience led me to resist this suggestion as over a period of at least 10 years I saw only one or two cases of significant vitamin K dependent haemorrhage per year with no deaths.

This has not been the experience in other parts of the United Kingdom, however, so it is now usually recommended that all babies are given routine treatment, especially as vitamin K, can now be given orally (though with slightly less assurance of bioavailability). An acceptable compromise has been suggested by Tripp and McNinch.1

‘For reasons of acceptability to parents, safety, convenience, and cost we currently use 1 mg oral dose of vitamin K, for routine prophylaxis and continue to use intramuscular prophylaxis in infants at special risk from HDN [haemorrhagic disease of the newborn], . . . We have now used this policy in some 25 000 babies and have not seen any further cases of HDN’.

While this is very gratifying, I am not alone in wondering why this has become necessary. Surely our efforts should be directed towards finding the cause of the deficiency and assessing the potential of preventive antenatal treatment.

Reference