Acute lower respiratory infections (ALRI).

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Hypoxaemia in children: “abnormal” values may be misleading

Duke et al are to be commended for their interesting report aimed to determine normal oxygen saturation values in healthy infants and children and to assess the performance of clinical signs for predicting hypoxaemia in sick neonates and children with and without acute lower respiratory infections (ALRI).1

Acute lower respiratory infections (ALRI) account for a substantial burden of disease in children and adults, pneumonia being the leading cause of deaths in children under five, particularly in developing countries. Tachypnoea and chest retraction have been shown to be the most useful clinical signs for determining the presence of pneumonia and thus they are widely used in the diagnosis and management of this condition in children.1 The World Health Organization pneumonia case detection and management programme,2 which relies on these simple signs, seems to be justified by the existing body of evidence.

Varying degrees of hypoxaemia may be present in children with pneumonia. However, surprisingly few studies have been performed to assess normal values of haemoglobin oxygen saturation (SpO2) through the use of transcutaneous pulse oximetry, at both sea level and high altitude. Singh’s response to Duke et al rightly emphasises that altitude of studies reported must be taken into account in the interpretation of their results.3 There are some reports on SpO2 values at mid- and high altitude settings in healthy and sick children.4–6 We previously reported normal values of SpO2 in 1264 healthy children and adolescents living at 4100 m.3

The main conclusions of these studies performed at different altitudes are: firstly, values considered abnormal at sea level are very frequently found at high altitude in healthy children; secondly, normal values vary for different altitudes; thirdly, recommended SpO2 cut offs for giving supplementary oxygen to sick children at sea level are clearly not applicable to high altitude settings, as according to these recommendations oxygen should be administered for values below 92%.4 There is a need to perform more studies for determining which cut off values for supplementary oxygen are related to better outcomes in sick children living at high altitude. Moreover, our study at 4100 m revealed that SpO2 values may be different according to different ethnic groups and history of exposure to high altitude. Higher SpO2 values in Quechua children suggest a better degree of adaptation to high altitude in native populations with a longer time to exposure to high altitude. This latter finding has obvious practical implications, as high altitude native children, with higher baseline oxygen saturation levels than newcomers or resident non-native children, may need oxygen at higher cut off SpO2 values when they are sick.

Singh is justifiably concerned on the cost of giving oxygen to children who may not need it. Oxygen may be unacceptable expensive for health services in developing countries, particularly at primary level, where most sick children seek health care. However, hypoxaemia may be a serious, life threatening problem in sick children, particularly at high altitude, and thus we repeated our study at 4100 m with new ethnic groups and history of exposure to high altitude.

We read with interest the article by Duke et al regarding hypoxaemia in acute respiratory and non-respiratory illnesses in infants and children in developing countries published recently in Archives.7 The authors have rightly pointed out the limited availability of published data on the incidence, significance and clinical signs predicting hypoxaemia in infants less than three months of age. With similar concerns we had conducted a study in infants less than two months, a part of which was published in the Archives.8 We found that tachypnoea, defined as RR>60/min, predicted hypoxia with 80% sensitivity and 68% specificity.9 In that study we also found six functional and behavioural responses as predictors of hypoxemia (table 1). Five of these six variables had a very good sensitivity to detect hypoxemia. A very high prevalence of hypoxaemia in the population studied by Duke et al is rather intriguing. Out of total 257 sick neonates and children 52%, were hypoxaemic. Among children with acute lower respiratory infection (ALRI) 73% and those with non-ALRI 32% were hypoxaemic. In an ongoing study we have measured oxygen saturation (by Nellcor® oximeter) in a prospective cohort of 683 children 2–59 months brought to paediatric emergency department (ED) with any respiratory symptom. Oxygen saturation using a fingertip sensor in these children at the time of arrival to ED ranged from 78–99%. The overall prevalence of hypoxemia defined as SpO2 <90% was 4.5% (table 2).

An additional 5.1% children had borderline hypoxaemia, i.e. a SpO2 value of 90%. This is similar to a prevalence of 5.9% hypoxaemia (defined as SpO2 <90%) in Gambian children, 2–33 months of age, reported by Usen et al.10 Even in our previous study of 200 infants less than two months, only 38.5% of the sick infants attending ED were hypoxaemic.11 A systematic review of studies on prevalence and predictors of hypoxemia in children by Lozano et al found that the prevalence of hypoxia was dependent upon a number of factors including the setting of the study. The prevalence ranged from 6–9% in outdoor setting to 31–43% in emergency departments to a maximum of 47% in hospitalised children.

Yet, in our study, which represents the situation near sea level (Chamarca is 3800 m topographically) and the setting of an emergency department, the prevalence of hypoxaemia is much lower than that reported at heights. In light of our data and published literature, we believe that either the definition of hypoxemia used by Duke et al is too liberal or the children with respiratory symptoms living at high altitude decompensate more frequently to develop hypoxia. More information is needed in this respect to formulate

PostScript

LETTERS

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References


Response to Duke et al

We read with interest the article by Duke et al regarding hypoxaemia in acute respiratory and non-respiratory illnesses in infants and children in developing countries published recently in Archives.7 The authors have rightly pointed out the limited availability of published data on the incidence, significance and clinical signs predicting hypoxaemia in infants less than three months of age. With similar concerns we had conducted a study in infants less than two months, a part of which was published in the Archives.8 We found that tachypnoea, defined as RR>60/min, predicted hypoxia with 80% sensitivity and 68% specificity.9 In that study we also found six functional and behavioural responses as predictors of hypoxemia (table 1). Five of these six variables had a very good sensitivity to detect hypoxemia. A very high prevalence of hypoxaemia in the population studied by Duke et al is rather intriguing. Out of total 257 sick neonates and children 52%, were hypoxaemic. Among children with acute lower respiratory infection (ALRI) 73% and those with non-ALRI 32% were hypoxaemic. In an ongoing study we have measured oxygen saturation (by Nellcor® oximeter) in a prospective cohort of 683 children 2–59 months brought to paediatric emergency department (ED) with any respiratory symptom. Oxygen saturation using a fingertip sensor in these children at the time of arrival to ED ranged from 78–99%. The overall prevalence of hypoxemia defined as SpO2 <90% was 4.5% (table 2).

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guidelines for general use. The cumulative data clearly suggest that hypoxaemia is more frequent in children living at high altitude. Interestingly most studies including that of Duke et al on this subject in children 2 to 59 months have been from high altitudes. It is most likely that geographic location, 1600m above sea level is responsible for the high frequency of "hypoxaemia" in their patient population. This, however, may not necessar-ily be true for oxygen therapy. If the definition of hypoxaemia suggested by Duke et al were to be applied as a guideline to oxygen therapy almost half of their patients would need oxygen therapy. We need to answer as to whether oxygen therapy makes any difference to outcome of patients labeled as hypoxicemic using cut off limits proposed by Duke et al. It may also be worthwhile to conduct studies with a large sample size at sea level (plains) and in various settings before reaching a conclusion about SpO2 cut off for hypoxia at heights.

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References

2 Rajesh VT, Singh S, Kataria S: Tachypnoea is a good predictor of hypoxia in acutely ill children. Arch Dis Child 2000;82:46–49.

Hypoxaemia in developing countries

Drs Huicho, Singi, and Bharti make the important points that definitions of hypoxaemia should be based on altitude-specific normal values and that further research at sea level and higher altitudes is needed. An altitude-specific definition of hypoxaemia (being an arbitrary value of SpO2 more than 2 or 3 standard deviations below the normal population mean) may be different from the threshold SpO2 for giving oxygen. Other considerations for giving oxygen are at what level of SpO2, (at different altitudes) oxygen is beneficial, local resource availability, and, in an individual child, confounding factors including the duration of exposure to altitude, age, or co-existent disease such as brain injury, severe anaemia, pulmonary hypertension, and cardiac failure.

We report the findings of 30 Papua New Guinean neonates and children living at an altitude of 1600m to determine normal range of oxygen saturation. Hypoxaemia in our study was a SpO2 more than 25% below the mean. In practice our threshold for giving oxygen to sick children (SpO2 <85%; more than 3SD below the mean) was lower than this because of limited oxygen availability. However there is evidence that this is safe and effective.3 We stated that without further evaluation this should not be applied to hospitals at substantially lower altitudes than 1600m or in areas where oxygen availability is greater.

In comparing the prevalence of hypoxaemia between studies in different health facilities referral and selection biases are likely. Hypoxaemia will be more common in emergency departments of referral hospitals than at primary care settings, and more common still among children requiring hospital admission. The prevalence of hypoxaemia in children admitted to hospital was determined on thresholds for admission and case-mix. The 491 children in our study constituted about 20% of all the children admitted during the course of the study. A specialist paediatrician, whose practice was to oversee the care of sicker children, enrolled many of the patients, so this was a further source of selection bias. The much lower overall prevalence of hypoxaemia seen by Drs Singhi and Bharti in their emergency department population is therefore understandable. Of note the prevalence of hypoxaemia among sick neonates admitted to Goroka Hospital (43%) was similar to the prevalence among young infants (<2 months of age) attending the emergency department in Chandigarh (38.5%).7 It is interesting to consider the effects of altitude on hypoxaemia in children with pneumonia. Some populations living at higher altitudes have a greater tendency to pulmonary hypertension; this susceptibility may be genetically determined.8 Dr Huicho’s statement that ethnic differences in SpO2 at the same altitude are important. At altitude in response to hypoxaemia, pulmonary blood flow is shunted to the lung apices associated with an exaggerated vasoconstric- tion in the basal lung.9 This may have an adverse effect on ventilation perfusion match- ing in the supine position. In addition cardia- c expression of natriuetic peptides increases in parallel with pulmonary artery pressure.10 These and other pathophysiological changes may account for the greater severity and pro-longed duration of hypoxaemia seen at higher altitudes.9,10 It is important to evaluate the simple intervention of nursing children with pneumonia and hypoxaemia at high altitude in an inclined head-up position, rather than supine, to determine if this reduces the sever- ity of hypoxaemia. There is a need for more evidence about the prevalence of hypoxaemia at sea level and different altitudes; which children benefit from oxygen; for how long oxygen should be given and the best ways to deliver oxygen in remote settings. Controlled trials of oxygen in mild hypoxaemia may not be justified for ethical reasons, but other evidence will be informative. Before the intro- duction of pulse oximetry in Goroka we used the World Health Organization guidelines for giving oxygen (cyanosis, inability to feed or severe respiratory distress). With the intro- duction of pulse oximetry we set a threshold for giving oxygen at SpO2 85%. The severe pneumonia case-fatality rate fell from 10% to 2% (26/258) pre-pulse oximetry to 5.8% (65/ 1116) 2 years later.7 In highland PNG children cyanosis was only detected in 44% of those with an SpO2 <85% and 63% (more than 3SD below the mean for normal children in Goroka) resulted in improved outcomes, and was within available resources. The costs of oxygen and logistics of transporting cylinders are major problems in many developing countries; Dr Huicho is right that these are important public health chal- lenges. They call for innovative research and development into how best to supply oxygen to children who need it. The role of oxygen concentrators need to be further explored;11 the combination of concentrators with pulse oximetry would be appropriate technology for many hospitals in developing countries. In- creasing the availability of any drug that is crucial to the management of more than 20% of children hospitalised worldwide should be a very high priority; oxygen is one such drug.

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References

5 Rajesh VT, Singi S, Kataria S, Tachypnoea is a good predictor of hypoxia in acutely ill children. Arch Dis Child 2000;82:46–49.
Pharmacogenomic can give children safer medicines

I read with great interest Clarkson and Choonara’s paper on the fatal suspected adverse drug reactions (ADRs) in the UK, and I strongly agree with their conclusions, namely that an evidence based approach to drug treatment is needed to minimise fatalities due to drug toxicity in children. However, recent evidence also suggests that we are now ready for a gene based approach to drug treatment allowing to further minimise the occurrence and the severity of adverse drug reactions. Increasingly complex genetic knowledge can already be used to elucidate mechanisms underlying the adverse events of drugs, particularly in the case of pharmacogenomic work with Bosnian refugee families.

In a recently published systematic review, the authors found that more than half of the drugs cited in ADR studies are metabolised by at least one enzyme with a variant allele known to cause poor metabolism, suggesting that genetic variability in drug metabolising enzymes is likely to be an important contributor to the incidence and severity of ADRs.

Ketotic acid levels may alter osmoticity in diabetic ketoacidosis and precipitate cerebral oedema

In a study of DKA we found that the mean osmoticity at admission was 318 (SD 12.9; range 291–337). Further, we also found that the calculated osmolality (calculated osmolality = 1.86(Na + K) + Urea + Glucose) was only 289 (range 282–304). This suggests hypertonicity is common in DKA and calculated osmolality is used to estimate true osmolarity. The mean osmolar gap was 29 (range 14–48). The osmolar gap between true and the calculated osmolality, is made up of unmeasured substances like ketoacids. The osmolality of ketoacids have been ignored in the past, as they are considered to be rationally inactive and not contributing to osmoticomity. A study done by us (submitted for publication) has demonstrated that ketoacids (acetocetates) are osmotically active. Acetocetate can influence fluid shifts across a semipermeable membranes. This is in contrast to urea, which is not osmotically active. Osmolality, osmolar gap, and ketone bodies are not measured during the management of DKA. A rapid fall in ketone body levels can result in failure to detect the osmolar gap and osmoticity of the serum and lead to cerebral oedema. In a recent paper looking at the risk factors for development of cerebral oedema in DKA, the author noted that since none of the “relevant variables” (serum glucose concentration, age, ketone body levels) were known the serum osmotic concentration during treatment, rate of fluid and sodium administration were associated with the risk of cerebral edema, their data did not support the theory that a rapid decrease in extracellular osmolarity during treatment results in osmotic median swelling. Osmolality and osmolar gap were not measured, nor was ketone body levels studied (personal communication, Glaser N). Our studies demonstrate that the ketone level is probably a “relevant variable” that needs to be estimated before we can be certain that rapid decrease in extracellular osmolarity did not occur. In summary we suggest that changes in ketone body levels be considered, as a factor that can be partially responsible for the cerebral edema often seen during treatment of DKA. We will be glad to share our data at any summit of experts convened to study the enigma of cerebral edema in DKA.

References


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Inward and Chambers have called for a rethink of the management of diabetic ketoacidosis. In their article they quote a study by Grove et al. suggesting that pediatricians overestimated the quantum of dehydration in DKA. Over correction of dehydration is implicated in precipitating cerebral oedema. On the face of it, it seems implausible that pediatricians who are so adept at estimating degree of polyuria, context of gastrenteritis, diarrhea, and vomiting should err in estimating the dehydration in DKA, unless the dehydration of DKA has special features. Hypertonicity may be that special feature. We hypothesize that hyperosmotic dehydration can result in the tongue appearing dry and parched and when this is combined with aceticotone respiration of DKA, the treating pediatrician may classify the child as more severely dehydrated than he or she actually is.

In a study of DKA we found that the mean osmoticity at admission was 318 (SD 12.9; range 291–337). Further, we also found that the calculated osmolality (calculated osmolality = 1.86(Na + K) + Urea + Glucose) was only 289 (range 282–304). This suggests hypertonicity is common in DKA and calculated osmolality is used to estimate true osmolarity. The mean osmolar gap was 29 (range 14–48). The osmolar gap between true and the calculated osmolality, is made up of unmeasured substances like ketoacids. The osmolality of ketoacids have been ignored in the past, as they are considered to be rationally inactive and not contributing to osmoticomity. A study done by us (submitted for publication) has demonstrated that ketoacids (acetocetates) are osmotically active. Acetocetate can influence fluid shifts across a semipermeable membranes. This is in contrast to urea, which is not osmotically active. Osmolality, osmolar gap, and ketone bodies are not measured during the management of DKA. A rapid fall in ketone body levels can result in failure to detect the osmolar gap and osmoticity of the serum and lead to cerebral oedema. In a recent paper looking at the risk factors for development of cerebral oedema in DKA, the author noted that since none of the “relevant variables” (serum glucose concentration, age, ketone body levels) were known the serum osmotic concentration during treatment, rate of fluid and sodium administration were associated with the risk of cerebral edema, their data did not support the theory that a rapid decrease in extracellular osmolarity during treatment results in osmotic median swelling. Osmolality and osmolar gap were not measured, nor was ketone body levels studied (personal communication, Glaser N). Our studies demonstrate that the ketone level is probably a “relevant variable” that needs to be estimated before we can be certain that rapid decrease in extracellular osmolarity did not occur. In summary we suggest that changes in ketone body levels be considered, as a factor that can be partially responsible for the cerebral edema often seen during treatment of DKA. We will be glad to share our data at any summit of experts convened to study the enigma of cerebral edema in DKA.

References


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The Lazarus case, Life and Death Issues in Neonatal Intensive Care


When things go badly wrong in the perinatal period there has developed a culture in many “advanced societies” that demands a search for someone to blame. This search for guilt, accountability, punishment, and recompense often results in litigation.

In this thought provoking book John D Lantos describes such lawsuits as “our public morality plays” and uses his experience as a neonatologist, expert witness, and ethicist to create, debate, and crystallise relevant issues of ethics related to the neonatal intensive care of a fictional preterm infant who should have died but did not—The Lazarus Case.

A fictitious neonatologist, Dr Miller, decides to stop resuscitation of a very preterm infant who seems past reasonable care. The baby who might have died survived with severe neurological problems and the parents sue Dr Miller, alleging that stopping treatment was negligent. John Lantos places himself in the role of expert witness and uses questions put by the plaintiff’s lawyers to explore the moral, ethical, legal, and social factors and to illustrate the ambiguities, misunderstandings, responsibilities, and evasions highlighted by the perinatal care of a 25 week gestation infant.

A key question put to Dr Lantos by one lawyer was “Can studying philosophy tell you whether what a doctor does in a particular case is right or wrong?” Probably not is the final conclusion reached by Dr Lantos, but it was just as unlikely that definitive guidance would come from sociology, religious doctrine, strict medical protocols, or any other single source.

There have been many attempts over the past half century to face and explain the moral dilemmas associated with our attempts to save the lives, prevent damage, and encourage optimal development of critically ill preterm infants. The Lazarus Case reviews in a most effective, compelling, erudite, and compassionate way the enormous complexity of these issues. It is highly recommended to all who are concerned with the care of preterm infants and their families and is essential reading for those required to provide medico-legal advice on life and death issues in neonatal intensive care.

Forrester Cockburn

Problems in Paediatric Drug Therapy, 4th edn


There is increasing interest in both the clinical and scientific aspects of drug therapy in paediatric patients. This text book by the American Pharmaceutical Association is aimed at the North American market.

It is a reference book aimed at paediatric pharmacists. It covers a wide range of the problems associated with paediatric drug therapy, with chapters on the administration of drugs, fetal toxicity, drugs in breast milk, and both poisoning and drug toxicity, and also specific clinical areas, for example chemotherapy. There did not appear to be any order in the chapters. It would seem more appropriate to put chapter 13 on neonatal doses after chapter 3 on drugs in breast milk than after a chapter on chemotherapy.

There are several chapters with information on the dosage of medicines and it is of interest that these are divided into three separate chapters, one for neonates, one for infants/children and adolescents and one specifically for intravenous drugs. Despite having a chapter specifically on intravenous drugs, the chapters on drug dosing on both neonates and infants/children and adolescents contains details on the doses required for intravenous administration. This makes the book far more difficult to use. The dosage guidance is far less user friendly than publications such as Medicines for Children or the Neonatal Formulary.

It is for this reason I would not therefore recommend Paediatric Pharmacy departments to buy a copy of the book.

I Choonara