day (P 7). Both groups received iNO (5 ppm) or air from E21 to P7. Animals were evaluated at P3, P10 and P21 using immunohistochemistry, cognitive functions and mass spectrometry imaging.

iNO significantly attenuated the severity of hypoxia-induced WMD induced in neonatal rats. Specifically, iNO decreased white matter inflammation, cell death, and enhanced the density of developing oligodendrocytes and oligodendroglial maturation. Furthermore, iNO triggered an early upregulation of P27kip1 and brain-derived growth factor (BDNF). Whereas hypoxia disrupted early associative abilities, iNO treatment maintained learning scores to a level similar to that of control pups. In contrast to its marked neuroprotective effects, iNO induced only small and transient improvements of CLD.

These findings suggest that iNO exposure at low doses is specifically neuroprotective in an animal model combining simultaneously injuries of the developing lung and brain that mimicked CLD and WMD in preterm infants.

THE SIGMA-1 RECEPTOR AGONIST PRE-084 ATTENUATES INFLAMMATION-SENSITIZED NMDAR-MEDIATED EXCITOTOXIC BRAIN INJURY IN NEWBORN MICE

doi:10.1136/archdischild-2012-302724.0009

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Excitotoxicity and inflammation play crucial roles in the etiopathogenesis of perinatal brain injury. We have shown that the sigma-1 receptor agonist 2-(4-morpholinethyl)-1-phenylcyclohexanecarboxylate (PRE-084) protects against N-methyl-d-aspartate (NMDA) receptor-mediated excitotoxic brain injury. In models of adult central nervous system pathology, PRE-084 has demonstrated potent anti-inflammatory properties, which makes it a promising candidate for countering inflammation-enhanced perinatal brain injury.

In the present study we evaluated the effect of PRE-084 in a neonatal mouse model of inflammation-sensitized excitotoxic brain injury.

From postnatal days 1 to 4, pups were pre-sensitized by intraperitoneal injection of IL-1beta (10ng). Two hours after the last IL-1beta dose, pups received an intracranial ibotenate injection, 1 hour after the insult they were randomly treated with i) 0.1 µg/g bodyweight PRE-084 or ii) vehicle.

Administration of PRE-084 resulted in a significant decrease in cortical grey (mean length of the lesion: 780.00±495.35 vs. PRE-084 433.33±116.51; n=8–9; p<0.05) and adjacent white matter damage (mean length of the lesion: vehicle 767.50±489.07 vs. PRE-084 391.11±126.14; n=8–9; p<0.05). No sex-specific differences in lesion size were detected (n=5–6; p=0.05). PRE-084 treatment significantly reduced the number of isolectin B4-positive activated microglial cells in perilesional white matter (mean number of isolectin B4-positive activated microglia vehicle 36.40±6.96 vs. PRE-084 19.93±11.99; n=5; p<0.05).

We are the first to report that PRE-084 reduces inflammation-sensitized NMDAR-mediated excitotoxic perinatal brain damage. Since sigma-1 receptor agonists are investigated in clinical trials in adult neurological diseases, they might be considered a promising therapeutic option also in perinatal brain injury.

FLUID THERAPY SHOULD BE GUIDED BY FLUID RESPONSIVENESS

doi:10.1136/archdischild-2012-302724.0011

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Background To predict fluid response is very Important because a little or excessive expansion may alter the prognosis of the child in shock.

Methods We review experimental and clinical articles in adult and children about parameters that could predict fluid responsiveness in shock. We also analyze our experimental data in pediatric experimental model of hemorrhagic shock.

Results The most used parameters to try to predict hemodynamic response to fluids are: static pressure parameters as central venous pressure (CVP); volume as global end diastolic ventricular index (GEDI) or stroke volume index (SVI); dynamic parameters, as pulse pressure variation (PPV) and systolic volume variation (SVV), and the response to a maneuver that increases blood volume without expanding the patient (leg raises). Several studies in adults suggest that hemodynamic volume parameters (SVI or GEDI) predict better the response to fluids than pressure parameters (PVC); that dynamic parameters (PPV and SVV) predict better the response to fluids that static parameters; and that maneuver leg raises maneuver is the best predictive parameter. However, the results of other studies are contradictory. In children there are few studies and there is no evidence that dynamic parameters are better predictors than static volume parameters. Our experimental studies confirm these findings. Preliminary data suggest that leg raise maneuver has not good predictive power in children.

Conclusion at this time fluid therapy in children with shock should be guided by fluid responsiveness. Macrohemodynamic, microhemodynamic and tissue parameters should be used to control the response to fluid therapy.
Background and aims  To determine if in an infant animal model of hemorrhagic shock, hypertonic albumin plus single bolus of terlipressin, as opposed to isotonic crystalloid, would improve global hemodynamic and perfusion parameters. No previous experience in children or infant animal models has been reported.

Methods  Prospective, randomized study in 30 two month-old piglets (9.9±2kg). Following mechanical ventilation, hypovolemia was induced by controlled 30 ml/kg bleed. After 30’ pigs randomly received: Normal Saline (NS) 30 ml/kg, n=10, Albumin 5% plus Hypertonic 3% Saline (AHS) 15 ml/kg, n=10, or single bolus of terlipressin 20 µg/Kg iv plus AHS (TAHS) 15 ml/kg, n=10, over 30 min. Heart rate (HR), mean arterial pressure (MAP), cardiac index (CI), brain tissue oxygenation by near infrared spectroscopy (bTOI), internal carotid artery flow (ICAF), arterial lactate and intramusosal gastric pH (pHg) were compared by ANOVA.

Results  30’ after bleeding as well as 30’, 60’ and 90’ after infusion no significant differences between groups were observed. However, 90’ after infusion the TAHS group presented trends towards higher MAP (NS: 71±8, AHS: 74±7, TAHS: 82±7 mmHg); CI (NS: 3.2±0.3, AHS: 3.8±0.3, TAHS: 4.2±0.3 L/min/m²); lactate (NS: 1.7±1.7, AHS: 0.8±1.4, TASH: 3.6±1.4 mmol/L); bTOI (NS: 42±5, AHS: 45±4, TASH: 48±6%); and ICAF (NS: 41±4, AHS: 42±4, TASH: 48±3 mL/min); with no differences in HR (NS: 166±11, AHS: 145±10, TASH: 159±9 bpm); and pHg (NS: 7.1±0.1, AHS: 7.2±0.1, TASH: 7.2±0.1).

Conclusion  All fluids achieved similar hemodynamic and perfusion endpoints without a significant improvement secondary to the use of terlipressin.

Introduction  Extravascular lungwater (EVLW) can be measured at the bedside using the transpulmonary thermodilution method (TPTD), which quantifies the amount of pulmonary edema. This technique has never been validated in conditions of high indexed EVLW levels measured in infants and young children. We compared EVLW_TPTD measurements with the transpulmonary double indicator dilution method (TPDD; ice-cold indocyanin green) and post mortem gravimetry.

Methods  In eleven newborn lambs pulmonary edema was induced using a surfactant wash-out lavage ALI model. Serial EVLW measurements by TPTD and TPDD were performed at various levels of lung water and the final EVLW values were compared with the post mortem gravimetry results. Data were analyzed using correlation statistics (Spearman’s coefficient of rank correlation (rθ)).

Results  A total of 25 simultaneous TPTD and TPDD measurements from ten lambs were analyzed with a median EVLW_TPTD of 24.0 (IQR 20.7) ml/kg. One lamb died before the measurements