

Common Neonatal Problems

A primer In Neonatal Medicine

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Disclaimer

This presentation is to help medical students upon the start of their rotation in Pediatrics. It is NOT to replace the recommended textbook.

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Objectives

By the end of this presentation the student should:

- Know the uniqueness of neonatal pathophysiology affecting illness presentation
- Know some of the most common neonatal problems and their management
- Know the impact of prematurity on neonatal health

Introduction

Age

- Gestational age (GA)
 - CGA = corrected gestational age
 - PCA = post conceptional age
 - PMA = post menstrual age
- Chronologic age
 - Postnatal day of life = start at 1 on birthday
 - Postnatal age = start at 0 on birthday

Birthweight

- LBW = low birthweight <2500 g
- VLBW = very low birthweight <1500 g
- ELBW = extremely low birthweight <1000 g

SGA

<10%

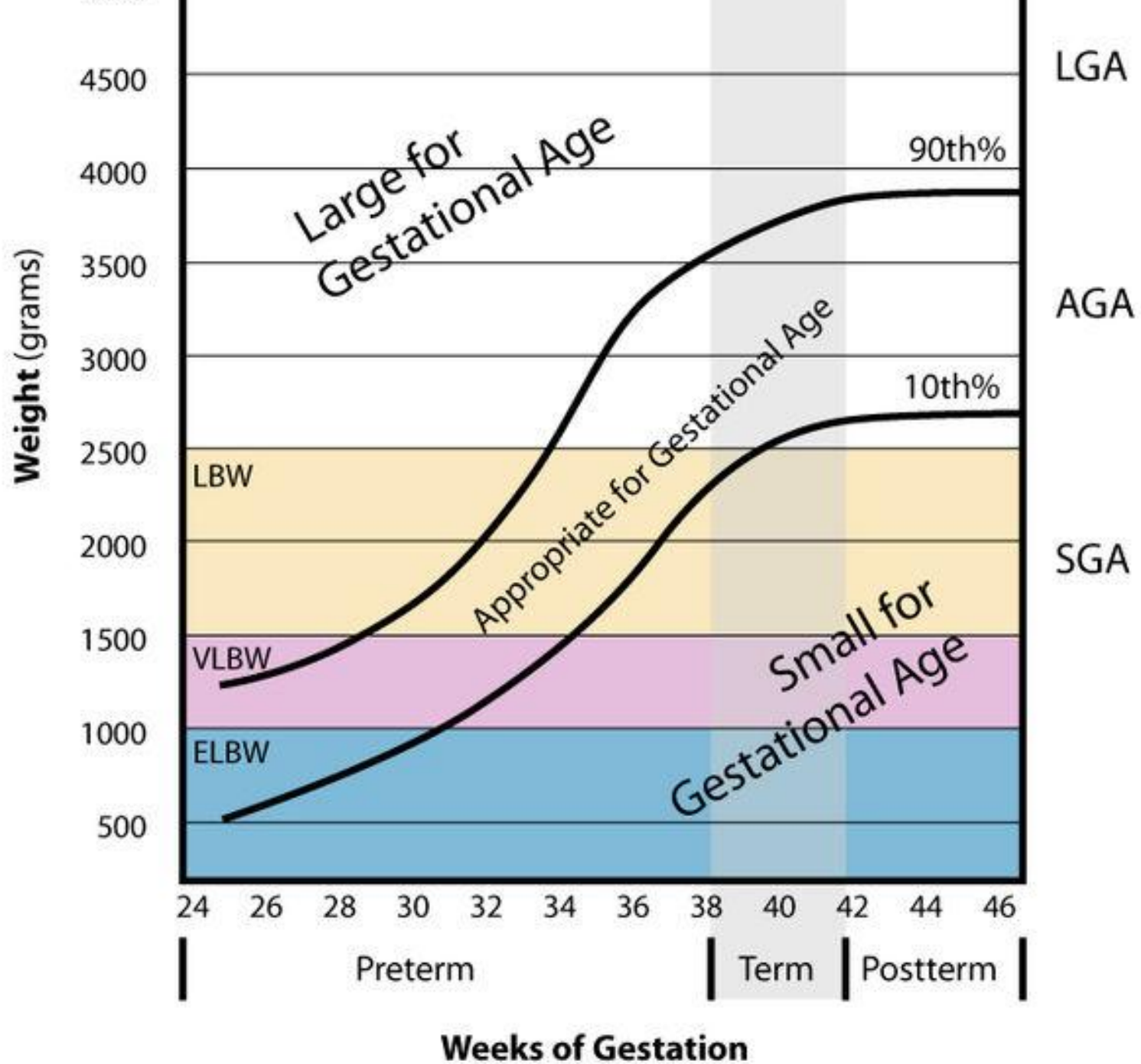
AGA

10% < - < 90%

LGA

> 90%





Signs *and* ~~Symptoms~~

- Hypothermia
- Fever
- Cyanosis
- Pallor
- Jaundice
- Apnea
- Tachypnea
- Convulsions
- Jitteriness
- Irritability
- Lethargy
- Pseudo-paralysis
- Poor feeding
- Vomiting
- Diarrhea
- Abdominal distension

Thermal regulation abnormalities

- Hypothermia: *(more common)*
 - Sepsis
 - Environmental
- Hyperthermia:
 - Environmental
 - Over clothing
 - Dehydration
 - Infection

Cyanosis

- Central cyanosis :
 - Respiratory insufficiency
 - CNS depression
 - Cyanotic heart disease
 - PPHN
 - Hypoglycemia
 - Sepsis



Peripheral Cyanosis



Pallor

- Anemia
- Acute hemorrhage
- Hypoxia
- Hypoglycemia
- Shock
- Adrenal failure
- Sepsis

Convulsions

- Electrolyte abnormalities : Ca, Na.
- Hypoglycemia
- Inborn error of metabolism
- Drug withdrawal
- Pyridoxine deficiency
- Cerebral anomalies
- Cerebral Infarction
- Intracranial hemorrhage
- Birth Asphyxia
- Meningitis
- Familial

Convulsions

- Type of convulsions
 - Subtle, focal or generalized
- Needs to be distinguished from:
 - Jitteriness
 - Apnea

Lethargy

- Asphyxia
- Hypoglycemia
- Sedation
- Cerebral defect
- Inborn error of metabolism
- Sepsis

Irritability

- Intra-abdominal conditions
- Meningeal irritation
- Drug withdrawal
- Congenital glaucoma
- Sepsis

Poor Feeding

- Prematurity
- Sick newborn infants:

- Especially Sepsis

Jaundice

- First 24 hours: *(almost always pathologic)*
 - Erythroblastosis fetalis
 - Hemolysis
 - Sepsis
 - CMV
 - Congenital rubella
 - Toxoplasmosis

Jaundice

- After 24 hours:
 - Physiologic
 - Hemolytic anemia
 - Inborn Errors of Metabolism (e.g. Galactosemia)
 - Hepatitis
 - Congenital infections
 - Sepsis

Vomiting

- GI obstruction
- Pyloric stenosis
- Over-feeding
- Milk allergy
- Increased ICP
- Sepsis

Abdominal Distention

- GI obstruction
- Abdominal mass
- NEC
- Ileus
 - Hypokalemia
 - Sepsis

Pseudo-paralysis

- Fracture
- Dislocation
- Nerve injury
- Osteomyelitis

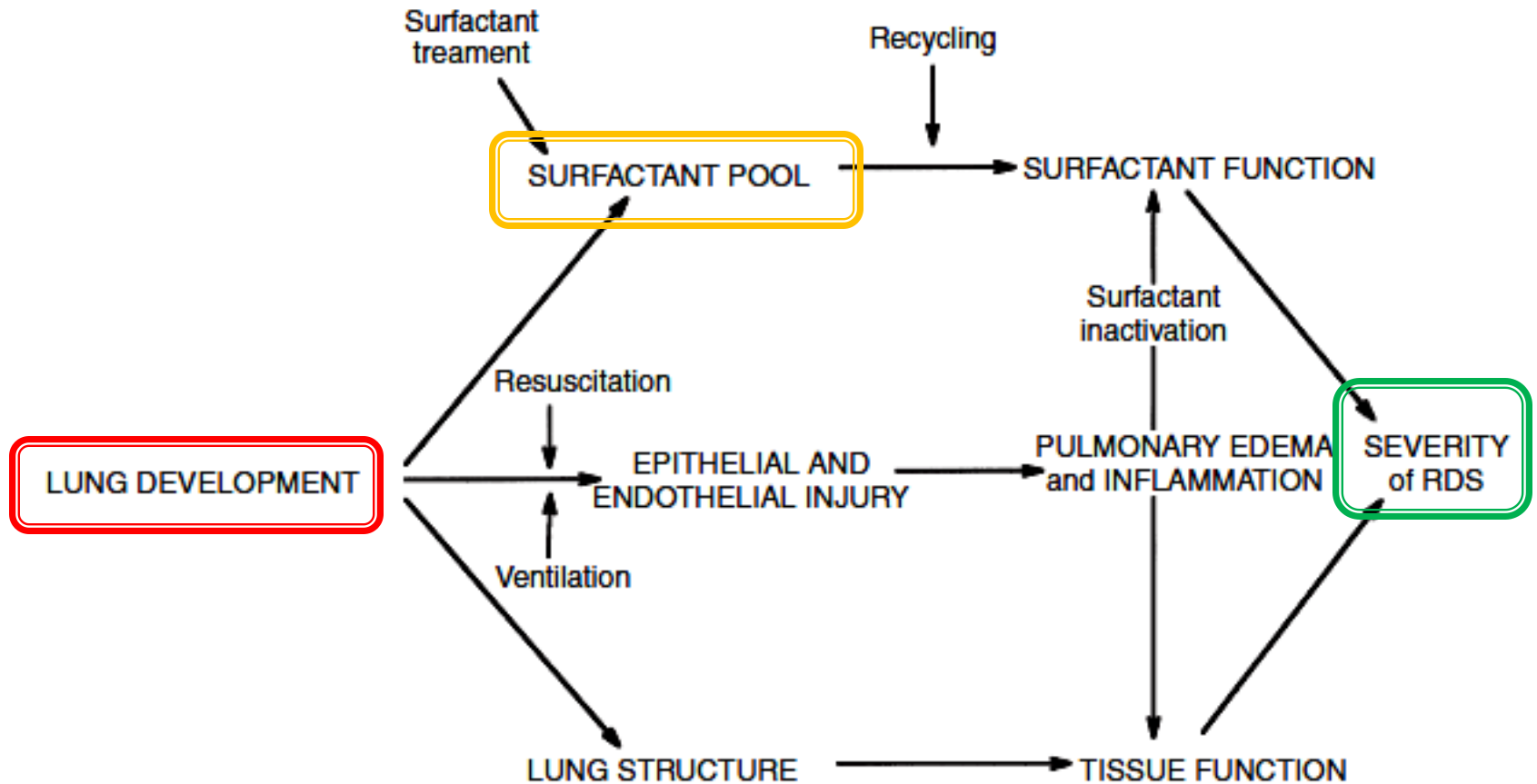
Selected Neonatal Disorders

Respiratory Distress Syndrome (RDS)

Hyaline membrane disease (HMD)



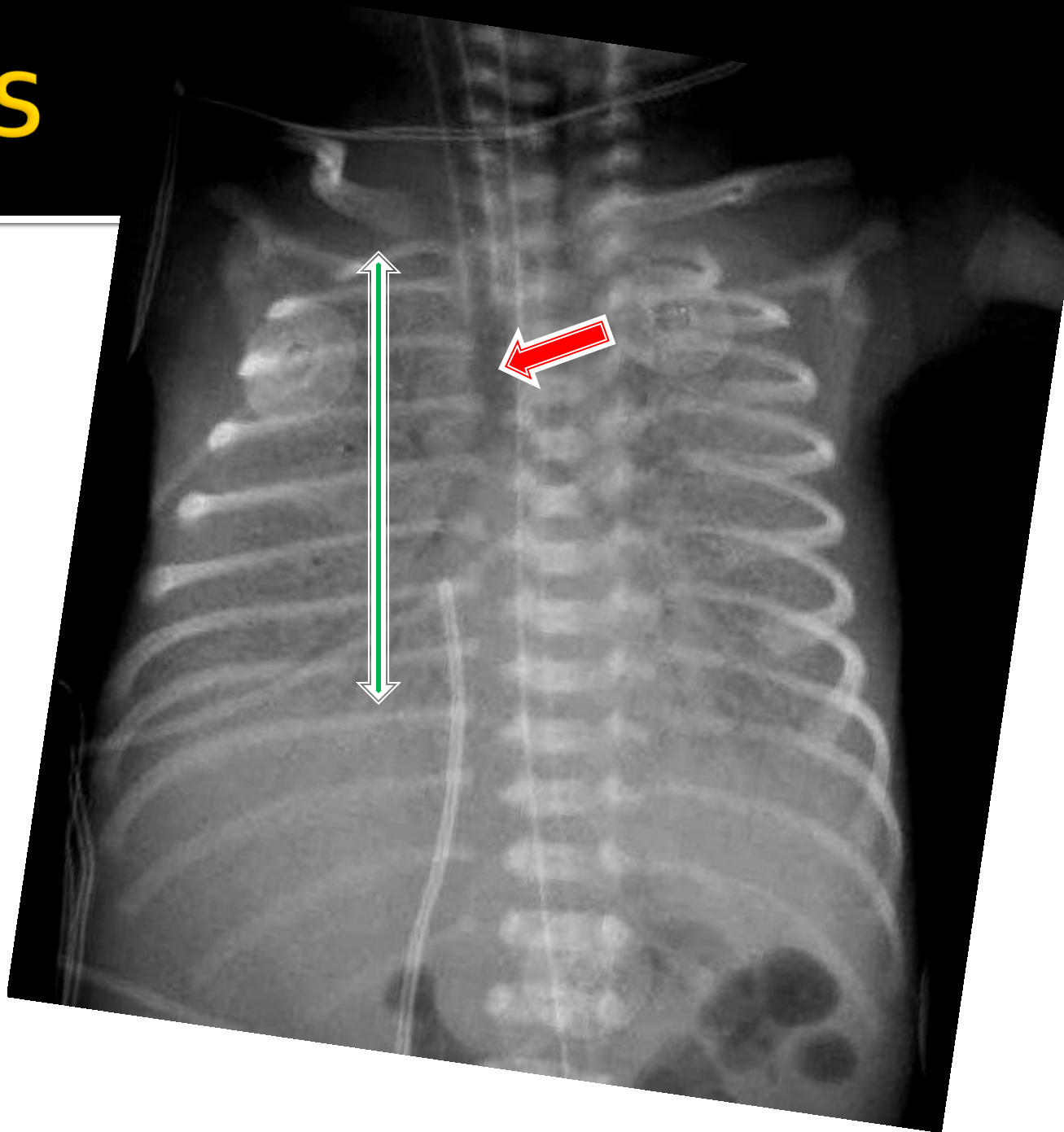
RDS etiology



RDS

- Course: 3-4 days
- Prevention:
 - Antenatal steroids, control of maternal diabetes
- Diagnosis:
 - *Clinical signs*: Cyanosis and Distress (Grunting, Retractions, Nasal flaring)
 - *Radiographic signs*: Ground-glass opacities, Air bronchogram, Low lung volumes

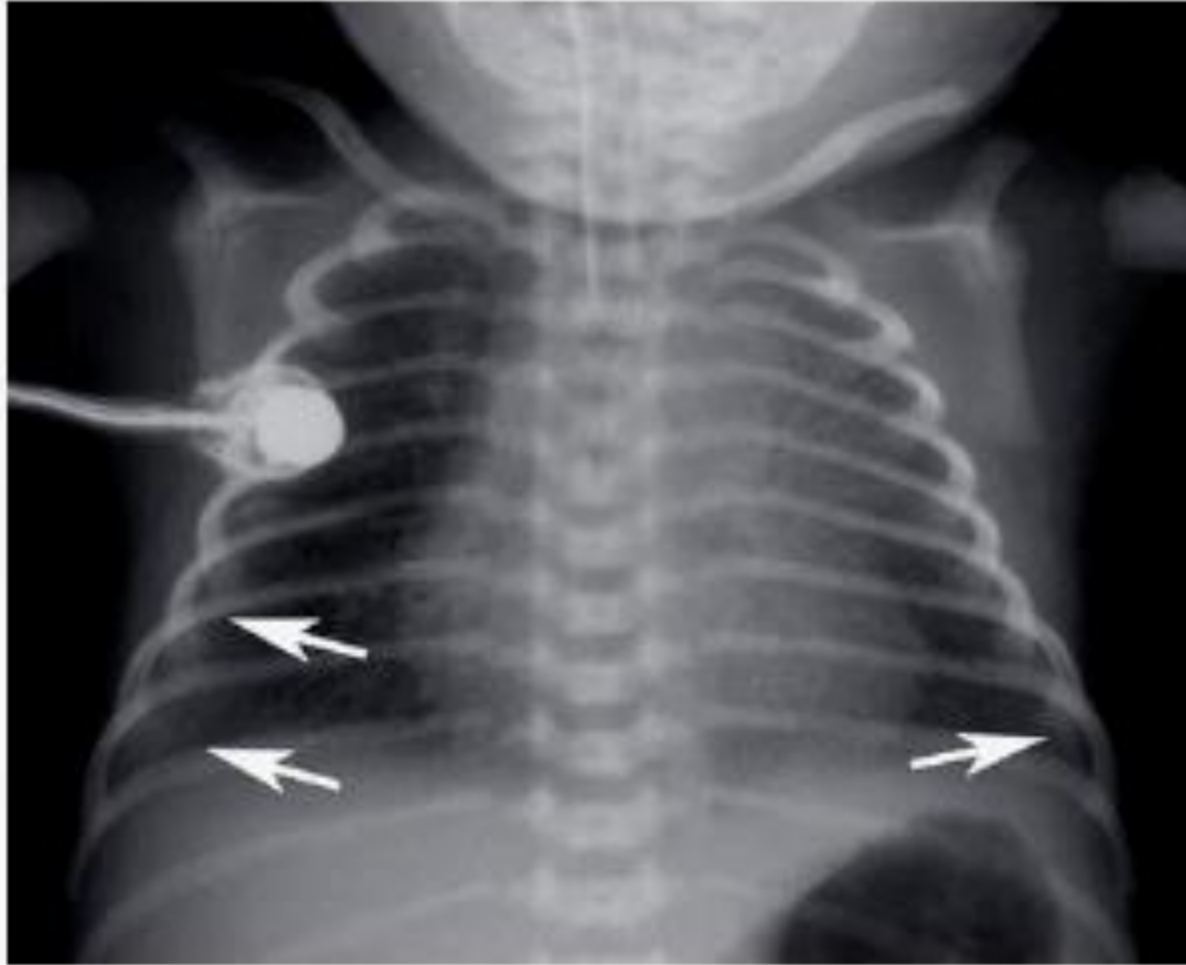
RDS



RDS management

- Exogenous intratracheal surfactant
 - Lowers surface tension at air-fluid interface
 - Within minutes, improved oxygenation and increased FRC at lower airway pressures
 - Usually, single treatment is enough because pneumocytes II recycle surfactant
 - Second dose may be needed in >6 hours if surfactant inhibition occurs (e.g. in MAS)

GBS pneumonia



TTNB



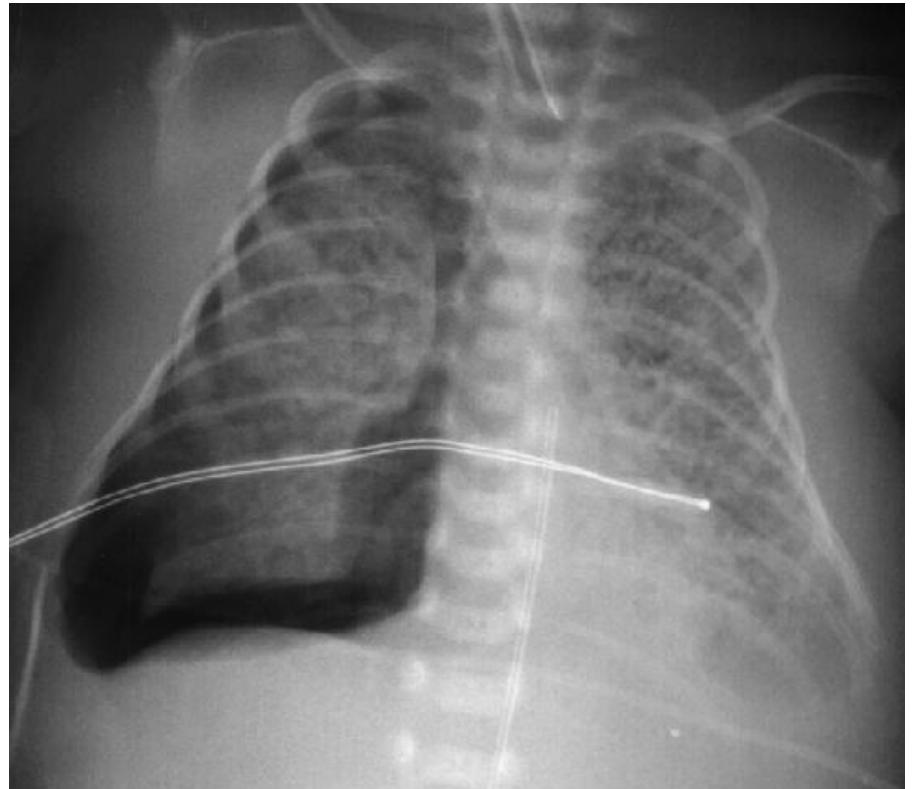
Fluids in the fissures

Meconium Aspiration Syndrome

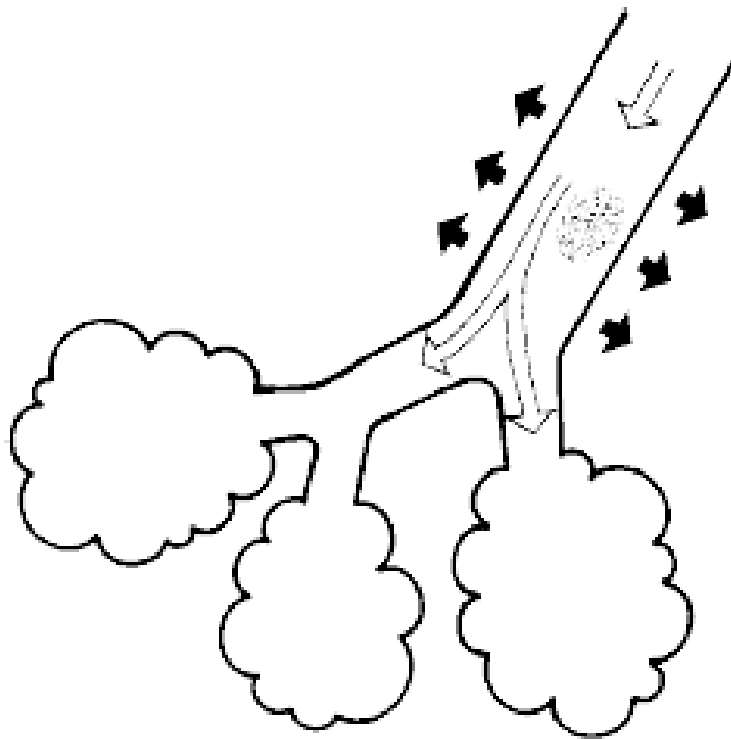


Pneumothorax

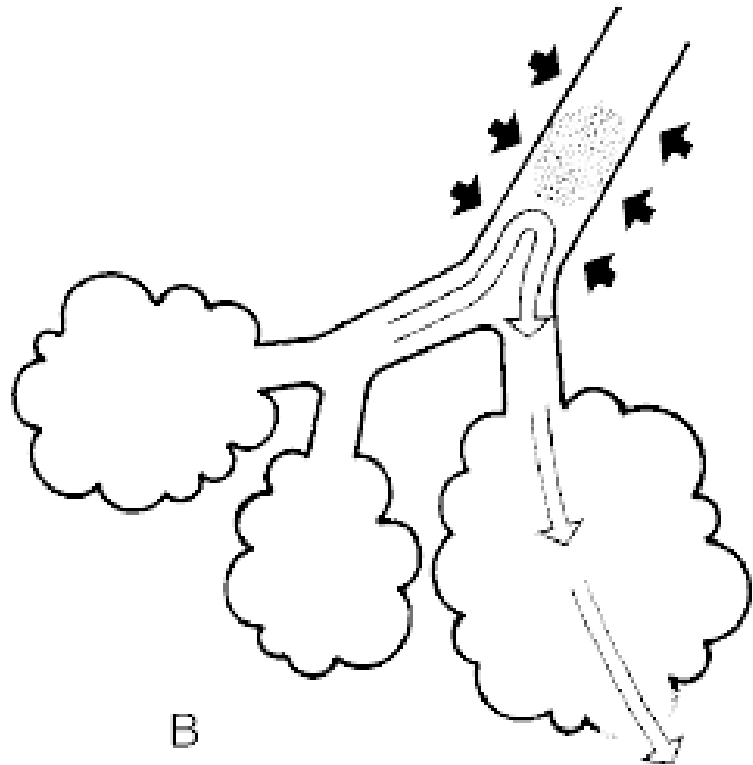
- Aymptomatic
(1-2% of all newborn)
- Spontaneous vs.
secondary
- Clinical
manifestations
- Diagnosis
- Management



One-way valve Mechanism



A



B

Diaphragmatic Hernia

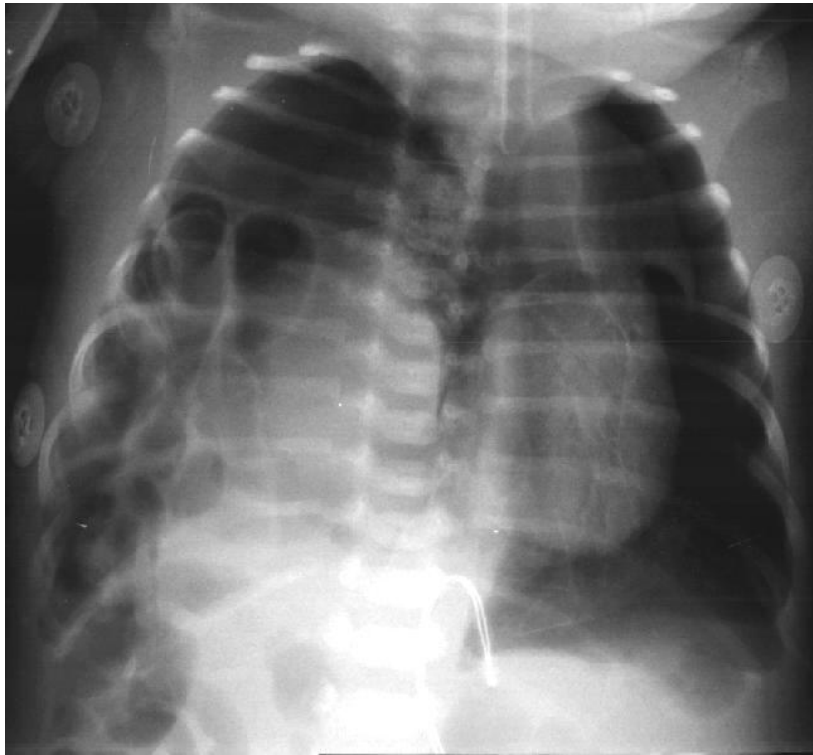


Diaphragmatic Hernia

- Congenital vs. acquired
- Most often left, and through the poster-lateral segment of diaphragm.
- Respiratory Distress (usually severe), cyanosis, bradycardia, scaphoid abdomen
- Diagnosis: signs and imaging
- Management : stabilization then surgery

Diaphragmatic Hernia

RIGHT



LEFT



Broncho-pulmonary Dysplasia (BPD)

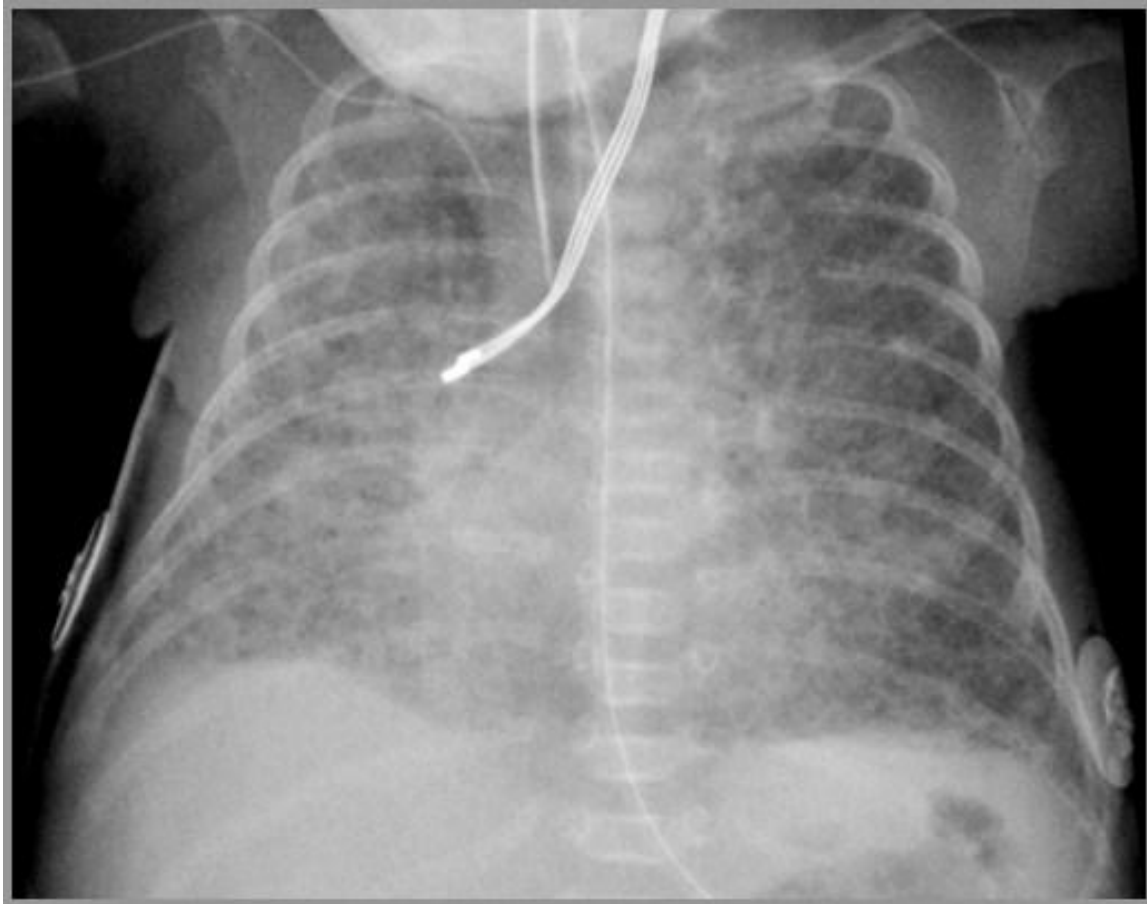
Chronic lung disease (CLD)



BPD

- Lung injury due to:
 - Barotrauma
 - Volutrauma
 - Oxygen toxicity
- Defined by the need for oxygen therapy or respiratory support at 36 weeks post-menstrual age (PMA)
- Management options ???

BPD



Apnea of prematurity (AOP)



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AOP

- Cessation of respiration for 20 seconds, or for 15 seconds associated with cyanosis, pallor or bradycardia
- Respiratory drive in preterm infants is
 - Less developed in response to hypercarbia
 - Transiently increased then decreased by hypoxia
- Preterm infants are at 3-4 increased risk of SIDS than term infants

AOP

- More common during sleep
- Uncommon if birth after 34 weeks of gestation
- May persist in VLBW infants until 44 weeks postmenstrual age.
- May recur following general anesthesia (GA):
 - Preterm < 44 weeks PMA who receive GA requires 24 hour monitoring

Types of AOP

- Central apnea
 - Lack of respiratory drive and effort, Typically brief
- Obstructive apnea
 - Presence of central drive and respiratory efforts
 - Cessation of respiratory airflow due to airway obstruction
- Mixed apnea
 - Central apnea in response to hypoxia of obstructive apnea
 - Most common, Can be quite prolonged

Identifiable Causes of Apnea

Not all apnea in the preterm is due to AOP

- Prematurity/immaturity
- Hypoglycemia
- Drugs
- Seizures
- CNS injury
- Sepsis!!!

Treatment of severe AOP

- Methylxanthine drugs (e.g. Caffeine)
 - Central stimulation
- Nasal CPAP
 - Splints upper airway obstruction
 - Maintains FRC → stabilized oxygenation
- Low flow nasal oxygen
 - Stabilizes oxygenation

Be careful not to hyper-oxygenate!

Periodic breathing

- Recurrent sequences of pauses in respiration lasting 5 to 10 seconds followed by 10-15 seconds of rapid respiration
- Evaluation and Treatment are NOT indicated

Patent Ductus Arteriosus (PDA)



PDA

- Persistence of fetal ductus arteriosus
- Blood flow determined by relative pressures
- Volume overload once pulmonary vascular resistance decreases

PDA

- Diagnosis:
 - Continuous **murmur**:
 - Best heard at upper left sternal border
 - Diastolic component is difficult to hear
 - “bounding” pulse
 - Decreased systemic diastolic **blood pressure**
 - Increased **O₂** and ventilatory requirements
 - Echocardiography is the gold standard

PDA

- Treatment:
 - Symptomatic
 - Indomethacin if < 14 (to 28) days chronologic age
 - Surgical ligation if two courses of Indomethacin were unsuccessful or contraindicated
 - Asymptomatic
 - closure after 6 months
 - Coil embolization or
 - Video-assisted thoracoscopic surgery (VATS)

Intra-ventricular hemorrhage
(IVH)

and

Peri-ventricular hemorrhagic
infarction (PVHI)



IVH & PVHI

Grade I (Mild)	Germinal matrix bleeding
Grade II (Moderate)	IVH filling 10-50% of the ventricles
Grade III (Severe)	ventricles >50% filled with blood, typically distending ventricle
Grade IV	Periventricular hemorrhagic infarction

Grade I



Grade II



Grade III



Grade IV



Necrotizing Enterocolitis (NEC)



NEC

- Acute multifactorial intestinal necrosis syndrome
 - Ischemia
 - Infection and Inflammation
 - Poor host protective responses

Clinical Presentation

SYSTEMIC SIGNS

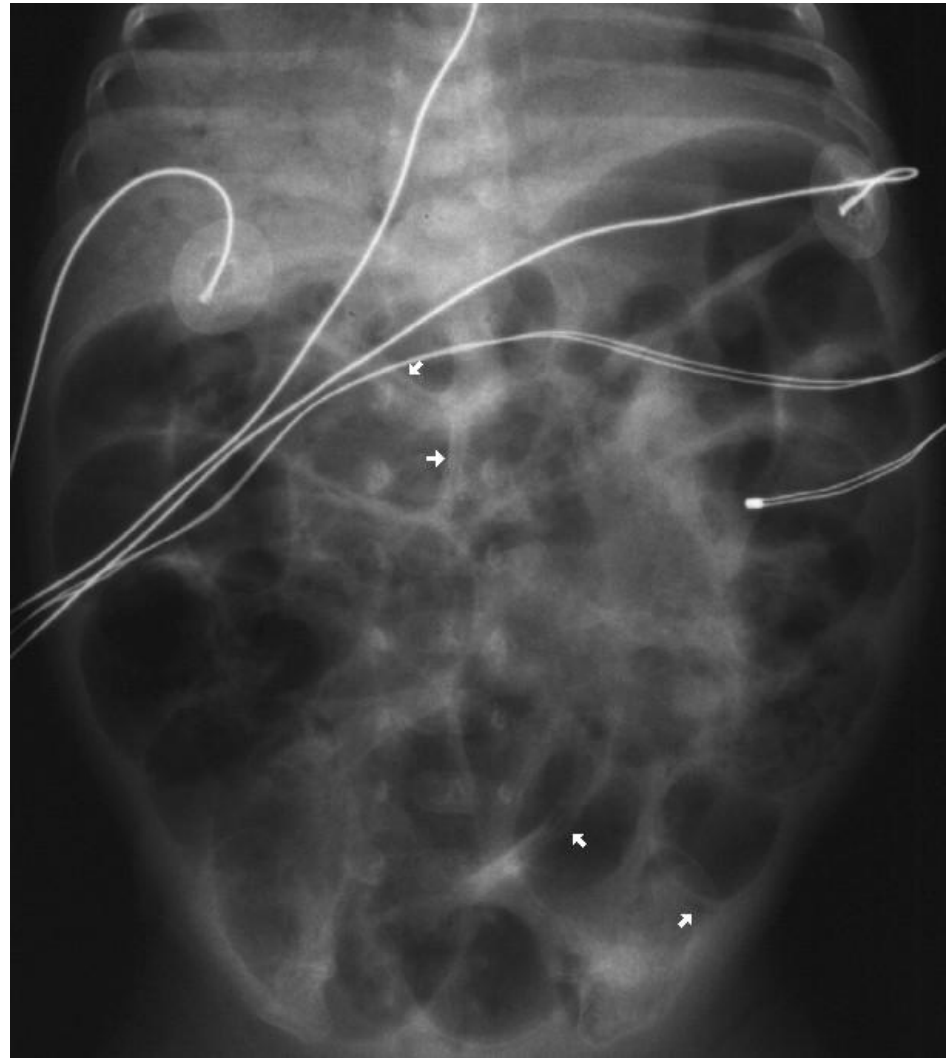
- Respiratory distress or apnea
- Lethargy
- Temperature instability
- Irritability or poor feeding
- Shock
- Acidosis
- Oliguria
- Bleeding

ABDOMINAL SIGNS

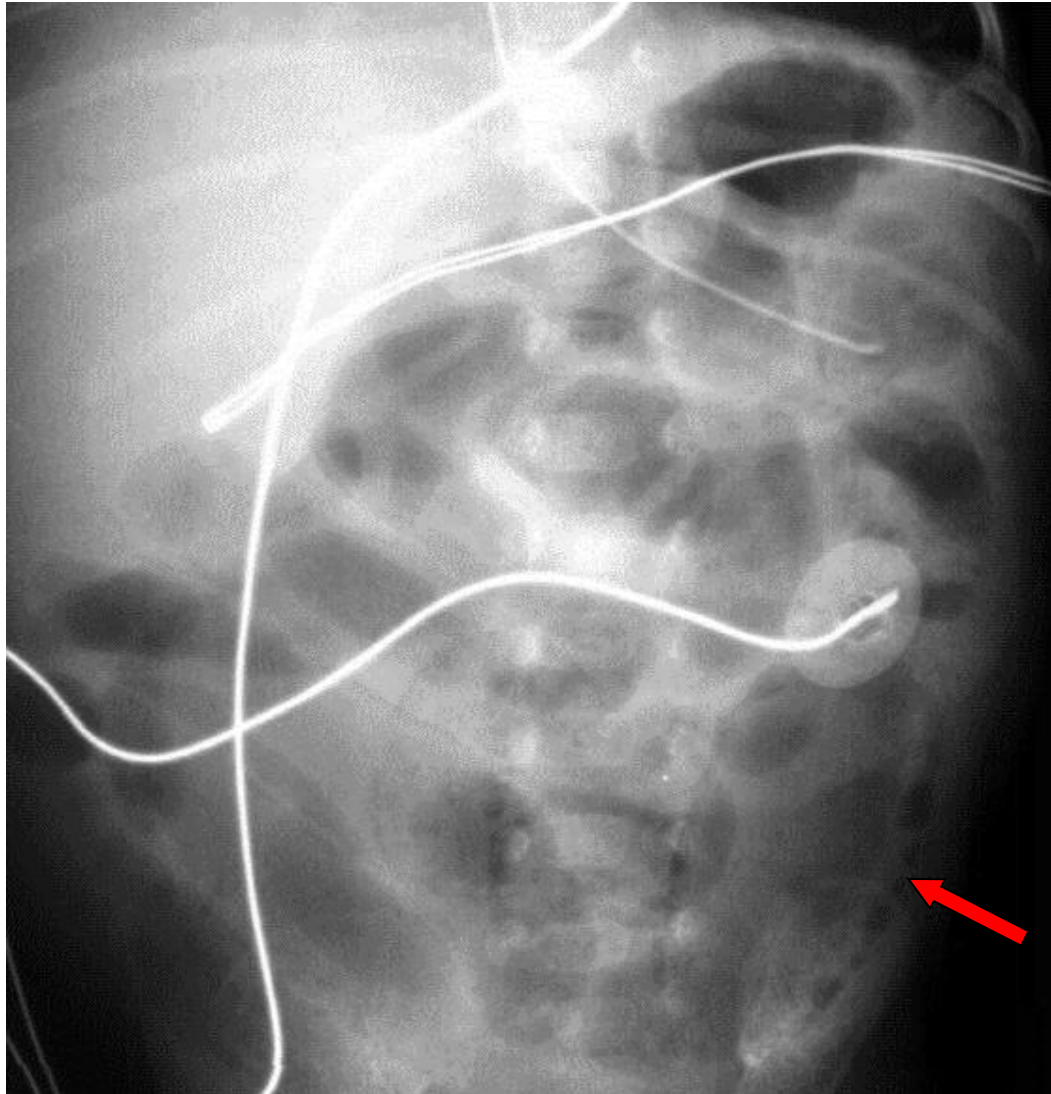
- Distention
- Tenderness
- Feeding residuals/Ileus
- Emesis
- Abdominal wall erythema
- Persistent localized abdominal mass
- Ascites
- Bloody stools

Radiographic features

- Ileus
- Bowel wall edema
- Fixed-position loop
- Pneumatosis (arrows) or portal venous air
- Pneumoperitoneum

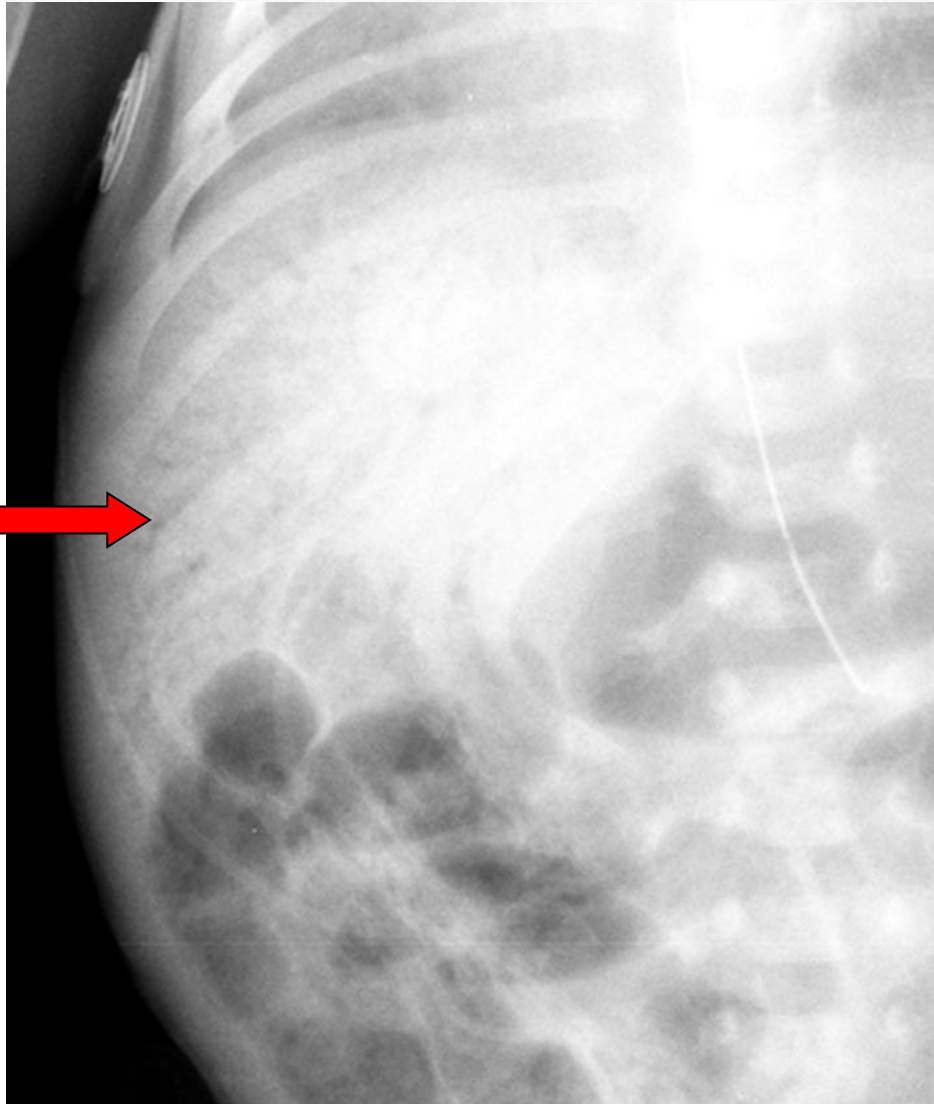


Pneumatosis intestinalis



Portal Venous Air

Portal venous air →



Pneumoperitoneum



In decubitus position, air rises to space between liver and body wall



Hypodensity of peritoneal cavity due to anterior air

NEC Evaluation

- CBC, Blood gas every 6-8 hrs until stable
- AP and decub KUB every 6-8 hrs until stable

Management

- Medical treatment
 - NPO for 7-10 days after normal KUB
 - Antibiotics
 - (Ampicillin, Gentamicin) for 14 days
 - Clindamycin or Flagyl if actual or impending perforation

Surgical Management

- Indications for surgical intervention:
 - Worsening clinical picture despite medical management
 - Persistent fixed loop on KUB
 - Abdominal mass
 - GI perforation
 - Signs of full thickness necrosis
 - Peritonitis: Ascites, Abdominal wall erythema
 - Persistent thrombocytopenia
 - Refractory metabolic acidosis

Retinopathy of prematurity (ROP)

formerly known as
Retrolental Fibroplasia (RLF)



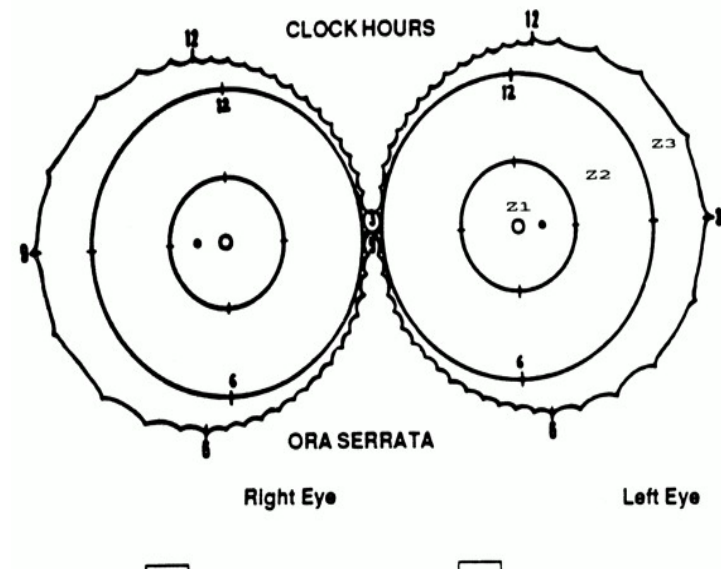
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ROP

- Develops only in incompletely vascularized retinas of premature infants
- Correlated with illness and hyperoxia
 - Acidosis, Hypothermia, Shock, and Asphyxia arrest vessel growth
- Abnormal growth in recovery phase results in “pile up” of vessels
 - Ridge without forward growth
 - Peaks ~40 weeks PMA

International Classification of ROP (ICROP)

- Zones (I, II, III)
- Stages:
 - I = line of demarcation
 - II = elevated ridge of vessels
 - III = extraretinal neovascularization (ERNV) into vitreous
 - IV = partial retinal detachment
 - V = complete retinal detachment
- Plus disease
 - Inflammation and vessels engorgement
 - Higher risk of scarring and retinal detachment



ROP Screening

- Dilated retinal exam at ≥ 31 weeks PMA (or 4 weeks chronologic age if born after 27 weeks of gestation)
- Whom to screen?
 - Who were born prior to 31 weeks of gestation OR
 - Who were born prior to 33 weeks of gestation AND had unstable course

ROP Treatment

- Indications
 - Zone 1 any plus disease
 - Zone 1 stage III disease
 - Zone 2 stage II or III *and* plus disease
- Laser ablation of peripheral retina
- Intravitreal bevacizumab (anti-VEGF agents)

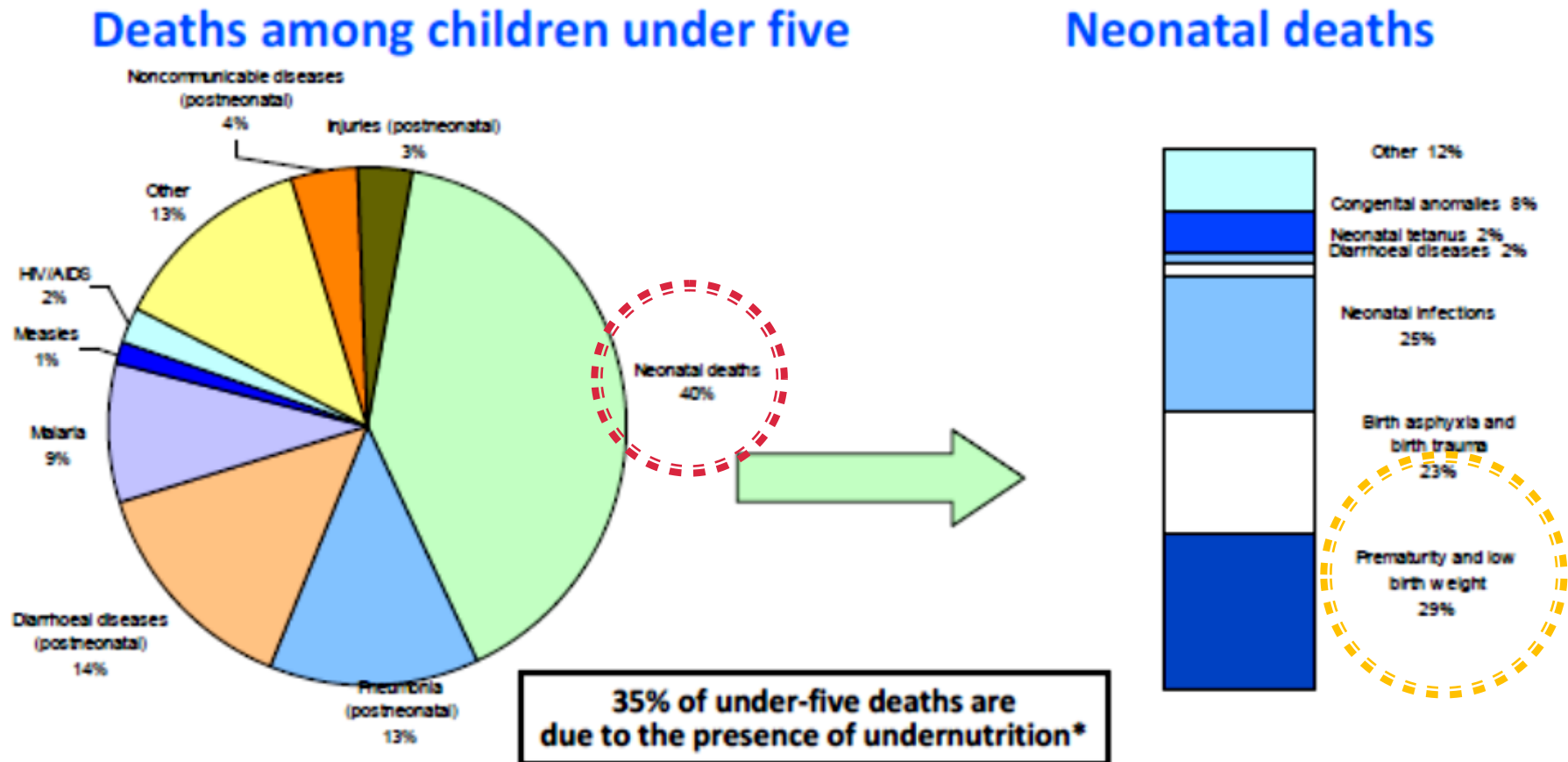
Finally!

The cost of prematurity



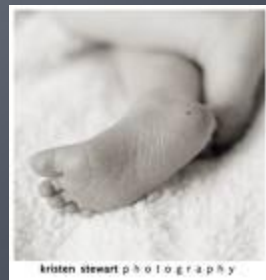
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Major causes of death in neonates and children under five – WHO 2008



Sources: (1) WHO. The World Health Statistics 2011; (2) *For undernutrition: Black et al. Lancet, 2008

THANK YOU



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