Anemia del prematuro pdf 2020

Anemia in a newborn is defined as below average concentration of hemoglobin or red blood cells for age. This is one of the most common problems in preterm infants and can have implications for their development. What are the symptoms? The most common sign is pale skin. Depending on the rate at which anemia occurs and its causes, other manifestations can be seen. Anemia can occur acutely, in which case the main symptoms are tachycardia, low blood pressure and poor general condition. If anemia occurs chronically children may not have any symptoms, but you may also face problems with stunting, there is fatigue, heart noise and pallor. Why is this happening? The causes of anemia are many, but they can usually be summarized in: Anemia for blood loss (hemorrhagic anemia): bleeding can occur several times: before childbirth: when the blood is transferred between the fetus and the mother, between the fetus and the placenta or between the two fetuses if they are twins. During childbirth: due to problems in the placenta (placenta, placental detachment...), problems in the umbilical cord (rupture of the umbilical cord, umbilical cord hematoma...) or problems in the uterus (rupture of the uterus...). After childbirth: internal or external bleeding of the baby or loss secondary to blood extraction. Increased anemia in the destruction of red blood cells (hemolytic anemia): The destruction of red blood cells can be caused by several causes: congenital diseases of red blood cells, which make their form or function unprepared and break down at an early stage. Immune diseases: Red blood cells are destroyed by the child's own immune system, in response to various stimuli (own, maternal or toxic). Acquired diseases: infections, defects of various nutrients, metabolic diseases. Anemia by reducing the production of red blood cells of newborns by physiological anemia: during the first few weeks of life, the production of red blood cells decreases while increasing the proportion of hemoglobin A characteristic of an adult (instead of hemoglobin F, characteristic of the fetus). When the child is 8 to 12 weeks old, hemoglobin levels reach the lowest level (11 g/dL in the newborn and 9 g/d in a premature newborn). All of these changes are normal in full term newborns, but in premature neonatal anaemia a little more stressed than usual. Minimum haemoglobin levels are reached earlier (4-10 weeks of life) because red blood cells survive less and premature growth rates are higher. In addition, iron deposits are insignificant in preterm infants. In addition, there may be anemia due to the lack of red blood cells in the bone marrow. This can be caused by a birth defect or other causes such as infections. When should I consult? Every time the symptoms described above are observed. In any case, the subsequent consultation of a premature baby always includes the treatment and prevention of premature anaemia. How is it diagnosed? Diagnosis of anaemia requires a complete medical history, including family, maternity and detailed medical examinations. We also need a blood test, search for data on the source of anemia. Tests may be needed to rule out the underlying causes of anemia such as maternal and newborn blood, bilirubin levels in the blood, and others. How is it treated? It usually tries to prevent anemia before it appears. During the admission of children to neonatal wards, attempts are made to minimize blood flow to prevent further anaemia. If you need treatment, it will vary depending on the cause of anemia. If it is acute anemia, a blood transfusion will be given. To prevent chronic anaemia premature baby is recommended that everyone receives iron supplements, at least until adulthood or as long as the supplementary nutrition provides enough iron. Typically, a pediatrician is the one who guidelines this supplement and the one who decides the most appropriate time to take it off. Objectively determine the effectiveness of recombinant treatment of human erythropoietin (rH-EPO) in the prevention of premature anemia. Patients and the Method Case Study and Control, Non-Randomized, Retrospective 108 Preterm Weight Periods; 1,500 grams and Gestational Age 34 Weeks. Premature diseases affected by hemolytic or hemorrhagic diseases and/or death were ruled out in the first days of life. 54 patients were treated with PH-EPO (250 U/kg, subcutaneous, 3 times a week) for 6 weeks. Added oral ferrosulfate (4-6 mg/kg/day) and multivitamin complex. The results between the two groups are not significant differences in terms: gestational age, weight, ferritin, hemoglobin and hematocyte at admission, the number of extractions and days with mechanical ventilation. The number of blood transfusions per child per child in the group, not particularly EPO, was 1.46 ± 1.38 compared to 0.69 ± 1.19 in the contract (p. zlt; 0.002). 63% of children who did not need transfusion treatment versus 29% of the control group (r-lt; 0.001). The lowest average haemoglobin reached 8.72 ± 2.62 g/dL in the undated group, compared to one де 9,7 ± 2,08 г/дл-эль-ке-ло-локиби. Conclusions La dministraci'n profil'ctica de rH-EPO muestra una tendencia a disminuir el n'mero de transfusiones en los prematuros de bajo peso, siendo claramente eficaz en los pret'rminos estables con un peso, surpassing 1,000 grams. Anemia de la prematuridadObjectiveI assess the effectiveness of recombinant human erythropoietin (rH-EPO) in the preventive treatment of prematuridad anemia. Patients and methods We conducted an unspokeable, retrospective study of random control of 108 preterm infants with a birth weight of less than 1,500 grams and gestational age of less than 34 weeks. Infants with hemolytic or hemorrhagic diseases and those who died in the first days of life were excluded. Fifty-four patients were treated with rHEPO (250 U/kg subcutaneously, 3 times a week) for 6 weeks. Ferrosulfate supplement was also administered orally (4-6 mg/kg/day) with multivitamin complex. The results did not distinguish between groups in gestational age, birth weight, ferritin levels, hematocrit and haemoglobin when received, the number of blood samples and days with a ventilator. The number of blood transfusions per patient was 1.46 ± 1.38 in the control group versus 0.69 ± 1.19 in WG-EPO-treated infants (p zlt; 0.002). Sixty-three percent of infants in the treated group did not require blood transfusions, compared to only 29.7 percent in the untreated group (p.lt; 0.001). The lowest average hemoglobin was 8.72 ± 2.62 g/dL in the control group against 9.70 ± 2.08 g/dL in the rH-EPO group. FindingsProphylactic treatment of pH-EPO was effective in reducing the number of transfusions, mainly in stable newborns with a birth weight of more than 1000 grams. El Texto completo est' disponible en PDF copyright © 2000. Associacion Espanyol de Pediatric Esta revuaririn actualizada incluye 34 estudios con 3643 lactants. Todos los Anelisis compararon aee compared to un control gue conste de placebo o ning'n tratamiento. Los AEE tempranos redujeron el riesgo de uso de una o m's transfusiones de gl'bulos rojos (riesgo relativo t'pico (RR) 0.79, (IC) del 95%: 0.74 a 0.85; diferencia de riesgos t'pa (DR) -0.14, IC del 95%: -0.18 a -0.10; I2 - 69% para el RR y 62% para la DR (heterogeneed moderada); n'mero necesario tratar para un resultado beneficioso adicional (NNTB) 7, IC del 95%: 6 a 10; 19 estudios, 1,750 neonato). La Calidad de la Euidentia of the Bach era. La enterocolitis necrotizante se redujo de forma significativa en el grupo de AEE en comparaci'n con el grupo de placebo (RR t'pico 0,69; IC del 95%: 0.52 at 0.91; Dr. Typica -0.03; IC del 95%: -0,05 a -0,01; I2 - 0% pair RR y 22% par DR (bajaida heterogened); NTTB 33; IC del 95%: 20 per 100; 15 estudio, 2639 lactans). La Calidad de la eyidencia fue moderada. Los Datos Mostraron una reduccion cualquier deficit deficit 18 to 22 months in ESA (typical RR 0.62; 95% CI: 0.48 to 0.80; Typical DR -0.08, 95% CI: -0.12 to -0.04; NNTB 13, 95% CI: 8 to 25. I2 x 76% for RR (high heterogeneity) and 66% for moderate DR; 4 studies, 1,130 infants). The quality of the evidence was poor. The results show higher scores in the Bayley-II Mental Development Index (MDI) for 18 to 24 months in the ESA group (weighted average difference (DMP) 8.22; 95% KI: 6.52 to 9.92; I2 x 97% (high heterogeneity); three studies, 981 children. The quality of the evidence was poor. The total number of red blood cells per infant decreased by 7 ml/kg. The number of red blood cells per infant was minimally reduced, although the number of donors exposed to infants receiving blood transfusions was not significantly reduced. The data do not show significant differences in the risk of premature retinopathy (RP) at the ≥ stage with early EPO (typical PP 1.24, 95% CI: 0.81 to 1.90; Typical DR 0.01, 95% CI: -0.02 to 0.04; I2 x 0% (without heterogeneity) for HR; I2 x 34% (low heterogeneity) for DR; 8 studies, 1,283 infants). Mortality was not affected, although the results show a significant reduction in the incidence of intraventricular hemorrhage (HIV) and periveentricular leukatomalism (LPV). (LPV).

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