


Apnoea of prematurity guidelines

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Considered by the Committee of Clinical Practice July 2015 Prematurity Apnea (AOP) is defined as a respiratory failure that lasts more than 15 seconds and is accompanied by disaturation (SpO2 \leq 80%) or bradycardia (HR \leq 2/3 of basic HR) lasting \geq 4 seconds in children born before the age of 37 weeks of pregnancy^{1, 2}. The incidence of AOP is correlated with gestational age and birth weight. Seven percent of newborns born between the ages of 34 and 35 weeks of pregnancy, 15% at 32 to 33 weeks, 54% at 30 to 31 weeks, and almost all infants born at 29 weeks of pregnancy or 1000 grams of AOP⁴ exhibition. The beginning of AOP is usually between days 2 to 7 life, peaking around the 3rd day. AOP is primarily due to immaturity of respiratory homeostatic mechanisms and control of the upper respiratory tract (table 1)⁵, but can be exacerbated by other complications of prematurity (see below). Most apnea in preterm infants have a mixed type, i.e. central and obstructive. Table 1. Pathophysiological Mechanisms Participating in AOP⁶ Central Mechanisms of Peripheral Reflex Pathways Other Decreased Central Chemostism Hypoxic Ventilation Depression Upregulated Neurotransmitter Inhibitor (GABA, adenosine) Disruption of astrocytes Decreased carotid artery activity Of the body Increased activity of carotid artery of the body Laryngeal chemoreflex Excessive bradycardia response to hypoxia Genetic predisposition Sepsis Cytokines Bilirubin Differential diagnosis of apnea a child having apnea needs a full evaluation, especially if the beginning before day 1 or after day 7. Potential cause-and-effect or aggravating factors should be taken into account (this is not an exhaustive list). Mechanical or obstructive causes of local or systemic infections of respiratory causes such as atelectase, RDS, pneumothorax, etc. CNS diseases including IVH and convulsions Issues with thermoregulation and ambient temperature The presence of electrolyte imbalance syndrome Hypoglycemia Drugs such as opiates, prosthine, phenobarbitone, or neonatal abstinence syndrome Gastro-esophageal reflux apnea in late preterm or term baby and late onset of predominant apnea or apnea with the onset of AOP Management Consider other causes of apnea/treat appropriately - as higher positioning - Pron positioning can reduce the incidence of AOP by improving thoraco-odom.8 Optimization of respiratory support. Consider the onset or increase in positive pressure support, such as CPAP by 6-8 cm H2O. CPAP increases functional residual capacity, reduces breathing, improves oxygenation and reduces bradycardia⁹. If the child remains unstable on CPAP and caffeine citrate, consider NIPPV¹⁰. Intubation and ventilation should be considered if apnea require repeated IPPV through neopuf or significant stimulation (discuss with a consultant). Caffeine citra Кофеин цитрат лечение является эффективным в предотвращении или сокращении АОП. В испытании САР, цитрат кофеина также снизил заболеваемость БДД, тяжесть ROP, использование послеродовых стероидов, церебральный паралич и когнитивные задержки на 18 до 21 месяцев, особенно если началось в течение первых 3 дней у <1250g on= positive= pressure= support11,12= .= benefits= in= motor= function= and= visual= perception= persisted= at= 5= years= of= age13.= short-term= use= of= high= dose= caffeine= citrate= (20= mg/kg)= has= been= shown= to= reduce= extubation= failure= in= premature= infants14= doxapram= -- use= of= doxapram= infusion= can= be= considered= if= aop= continues= to= be= a= significant= clinical= problem= despite= high= dose= caffeine= citrate= and= cpap.= the= safety= and= efficacy= of= doxapram= have= only= been= studied= in= observational= studies= and= caution= should= be= exercised15,16.= transfusion= may= help= increase= o2= carrying= capacity= of= the= blood= but= the= evidence= is= limited17= -- consider= in= babies= if= obviously= very= anaemic.= there= are= no= fixed= guidelines= on= the= initiation= of= any= of= these= treatments.= as= the= assessment= of= apnoea= tends= to= be= subjective.= and= each= baby= needs= individual= assessment.= in= general= exercise= caution= in= giving= caffeine= citrate= to= babies= with= acute= respiratory= problems.= apnoea= often= indicates= respiratory= deterioration= needing= respiratory= support.= not= caffeine= citrate.= especially= in= the= first= 48-72= hours= of= life.= monitoring= babies= with= apnoea= babies= with= apnoea= severe= enough= to= consider= treatment= should= be= monitored= by= a= cardio-respiratory= monitor= and= pulse= oximeter.= once= the= baby= becomes= more= stable.= discuss= changing= to= an= apnoea= mattress= on= the= ward= round.= usually= this= is= at=>младенцев 32 недель беременности. Алноз сигнализации являются полезным дополнением к мониторингу. Тем не менее, 87% сигналов тревоги являются ложными при использовании комбинации мониторинга SpO2 и алноз сигнализации, с скоростью выше (92-94%) при использовании алноз сигнализации в одиночку^{18,19}. Поскольку эти машины чувствительны к движению, они могут обнаружить периоды отключения или гиповентиляции, а не истинного алноз. Текущие матрасы niCU алноз могут быть запрограммированы реагировать на 15 или 20 секунд отсутствия импульсов от зонда. Не обязательно делать обычные уровни на стабильных младенцах²⁰. Концентрации сыворотки должны быть получены при подозрении на токсичность. Терапевтический диапазон: 26-150 микромол/л и <400 micromol/L. Testing is a send-away to Christchurch hospital. Discontinuing Caffeine Citrate In most babies it will be possible to "grow-out" of the caffeine citrate dose (i.e., do not increase the dose of caffeine citrate with weight gain so that the mg/kg dose of caffeine citrate is slowly prior to stopping). Caffeine citrate can usually be stopped between 32 and 34 weeks' gestation if they have not had an apnoea, bradycardia or desaturation episode requiring intervention for approximately five days. At the latest, it should be discontinued at least 5 micromol/L.= testing= is= a= send-away= to= christchurch= hospital.= discontinuing= caffeine= citrate= in= most= babies= it= will= be= possible= to= "grow-out"= of= the= caffeine= citrate= dose= (i.e.,= do= not= increase= the= dose= of= caffeine= citrate= with= weight= gain= so= that= the= mg/kg= dose= of= caffeine= citrate= is= slowly= weaned= prior= to= stopping).= caffeine= citrate= can= usually= be= stopped= between= 32= and= 34= weeks'= gestation= if= they= have= not= had= an= apnoea,= bradycardia= or= desaturation= episode= requiring= intervention= for= approximately= five= days.= discontinuing= Caffeine= Citrate= in= most= babies= it= will= be= possible= to= "grow-out"= of= the= caffeine= citrate= dose= (i.e.,= do= not= increase= the= dose= of= caffeine= citrate= with= weight= gain= so= that= the= mg/kg= dose= of= caffeine= citrate= is= slowly= weaned= prior= to= stopping). Caffeine citrate can usually be stopped between 32 and 34 weeks' gestation if they have not had an apnoea, bradycardia or desaturation episode requiring intervention for approximately five days. At the latest, it should be discontinued at least 5 >. токсичность маловероятна <1250g>. <1250g>: before the child goes home. Continue monitoring apnea for at least 4 days after stopping caffeine citrate. Depending on the clinical situation, it can be either an apnea mattress or a cardio-respiratory monitor plus a pulse of oxymetry. For babies who go home, monitoring is usually for 4 days, with another way out of the apnea monitor before discharge. This is usually the decision of a consultant with or without the involvement of a respiratory team. Indications may be boundary night saturation monitoring, which is not serious enough to justify home O2 therapy or current episodes of disaturation in a child otherwise ready for discharge and other diagnoses have been ruled out. Home care nurses should be aware of the child being prescribed for caffeine citrate. These babies usually have homemade mattress apnea. The script must be arranged at least 3-4 days before the expected discharge date. A local pharmacy should be notified by a PIN or FLN caffeine citrate prescription, as the caffeine citrate solution lasts only 1 week and frequent deliveries will be required. The primary counselor of the child should be aware of the caffeine citrate and follow-up with the appropriate clinic (Neonatal Fellow/Neonatologist/Respiratory Paediatrician). The Tek/Stop plan should be discussed and put in a statement letter. Typically, these children will be able to grow out of a dose of caffeine citrate before stopping. The plan will likely include home oxymetry before stopping caffeine citrate completely. Parents will complete neonatal CPR training before the caffeine citrate is sometimes prescribed in term infants with apnea or disaturation episodes. There is some observational evidence of its use in children with apnea associated with other causes, such as bronchiolitic²¹. Use for apnea or desaturation in children, in term infants is not very common and is usually a consultant solution with or without the participation of a respiratory team. Links 1 Barrington K, Finer N. NATURAL-HISTORY APPEARANCE APNE. Pediatr Res. 1991;29(4):372-5. 2 Moriette G, Lescure S, El Ayubi M, Lopez E. Apnea prematurity: what's new?. Arch Pediatrician. 2010;17(2):186-90. 3 Martin RJ, Abu-Shaweeh JM, BairdTM. Prematurity apnea. Paediatr Respir Rev. 2004;5 Suppl A:S377-82. 4 Robertson CM, Watt MJ, Dina IA. Results for a very premature baby: what's new? Where are we going? Pediatr Neurol. 2009;40(3):189-96. 5 Abu Shawish JM, Martin RJ. Neonatal apnea: What's new? Children's pulmonology. 2008;43(10):937-44. 6 zhao J, Gonzalez F, Mu D. Apnea prematurity: from cause to treatment. 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