Patient 1: A two month old baby was admitted with pertussis chest infection and was invasively ventilated for nine days and on CPAP for seventeen days. The baby had right upper-lobe collapse with ongoing oxygen requirement on day 31 of illness, having not resolved with conventional chest physiotherapy. PEP was initiated in supported sitting using an infant face mask and a 1.5mm resistor. He received a total of 3 treatments over 2 days and was discharged home with no oxygen requirement and resolution of X-ray changes prior to discharge.

Patient 2: Four week old ex-premature baby (31 weeks) was admitted with RSV positive bronchiolitis, ventilated for six days and on CPAP for five days. Radiographic findings showed a right upper lobe collapse, persisting despite regular conventional chest physiotherapy. PEP was started on day 12 using an infant face mask and a 1.5mm resistor. On day 14, a repeat chest x-ray showed complete resolution of the right upper lobe collapse and the patient was discharged home the next day.

Conclusions: The use of PEP in infants is an under-reported but potentially beneficial modality in resolution of lobar collapse during acute illness.

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RISK FACTORS ASSOCIATED WITH EXTUBATION FAILURE (EF) IN EXTREMELY LOW GESTATIONAL AGE NEWBORNS (ELGAN)

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Aims: To analyze influence of perinatal characteristics(PC), mechanical ventilator(MV) parameters and early morbidity on EF of ELGAN with birth weight (BW)< 1000g.

Methods: This is a retrospective cohort of all ELGAN< 28 weeks gestational age(GA) and BW< 1000g born between 2004-2009 with MV started in the first week of life. EF was defined as the need for reintubation within 48h after the first extubation attempt.

Results: 165 infants were included. GA 25.9±1.1w, BW 788.2±126.5g. First extubation attempt was at 11.5±14.6d (median 6d). Nasal CPAP was used in all patients and nasal IMV in 78.4%. EF was 30.9%.

Comparing EF infants with those who succeed we didn't find any differences regarding PC. MV parameters and use of nasal IMV were similar between groups. EF group presented higher rates of late bronchopneumonia and MV length.

Extubation from A/C mode vs SIMV was earlier (7.6 vs 13.3d,p=0.007), with shorter time constant (51 vs 74.1, p=0.000) and higher mean airway pressure and rescue rate (7.1 vs 5.5 cmH₂O, p=0.000; 39.4 vs 24.5 rpm,p=0.000); compliance, minute-volume and EF (29 vs 29.6%) were similar.

ELGAN with BW< 750g had no significant difference in EF (37.3 vs 27.4%) although reintubation rate was higher (81.4 vs 51.4%,p=0.000).

Conclusion: This study does not support GA or BW as risk factors for EF in this population. BW< 750g did not determine a higher EF rate, although it could be a risk factor for later reintubation.

Extubation from A/C mode allows early extubation without increase of EF.

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UNSAFE SWALLOW IN CHILDREN: ARE WE DOING ENOUGH?

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Background: Recurrent chest infections are a common problem in children with unsafe swallow. Tracheostomy and gastrostomy are commonly performed in such children. However, it is not clear whether these interventions will resolve the problem.

Aim: Report the clinical profile of patients with unsafe swallow who have undergone tracheostomy and gastrostomy.

Methods: We retrospectively analysed children admitted to Paediatric Critical Care Unit in a tertiary referral hospital (March 2009-March 2010). We reviewed the indications for tracheostomy, associated co-morbidities, feeding adjuncts used, safety of swallow and the incidence of recurrent chest infections.

Results: Ten children were managed during this period with a median age at tracheostomy was 8 months (Range 1 week to 15 years). Common indications for tracheostomy included failed / difficult intubation (2), bilateral vocal cord paralysis

(1), failed extubation and prolonged ventilation requirement(4), airway protection following trauma(2) and cystic hygroma(1). Associated co-morbidities were Chronic Lung disease(3), Congenital Myasthenic syndrome(1), Cystic hygroma(1), hypoventilation syndrome(1), Cerebral and Renal Haemolytic Uraemic syndrome(1), Road Traffic accident with multiple organ injury(2). Out of 10, six children had unsafe swallow. Recurrent aspiration pneumonia remained a major problem despite these interventions.

Conclusions: Interventions such as tracheostomy and gastrostomy may not resolve the issues with recurrent chest infections in children with unsafe swallow. There is a need to explore other interventions to reduce recurrent aspiration pneumonitis in such population.

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RESPIRATORY OUTCOMES OF LATE PRETERM INFANTS

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Several studies have shown that late preterm infants (LPI) are at higher risk for respiratory disorders than term infants.

Objective: To evaluate occurrence of respiratory disorders, need for respiratory support, use and timing of specific adjunctive pulmonary therapies in LPI.

Methods: Using electronic medical charts, we performed a retrospective analysis of all LPI (34 0/7 to 36 6/7 wks) born from January 2005 to December 2009 in a tertiary level NICU.

Results: During the study period, 856/14443 infants born alive were LPI (5.9%). They accounted for 58.9% of preterm births. Majority of LPI were 36 weeks (53.9%), followed by 35 weeks (28.4%) and 34 weeks (17.8%).

Transient tachypnea of the newborn (5.8%) was the most common pulmonary illness, followed by respiratory distress syndrome (4.7%), apnea (1.5%), air leak (1.3%) and persistent pulmonary hypertension (0.5%). Composite respiratory morbidity was 12.4%:

A total of 69 (8.1%) patients received NCPAP only, 19 (2.2%) mechanical ventilation, 17 (2%) surfactant, 8 (0.9%) chest tube and 4 (0.5%) inhaled nitric oxide.

Fig 1 shows the highest levels of respiratory support for each GA.

Fig 2 shows times at which each treatment was started.

Median length of positive pressure ventilation was 40.5 hours (IQR 16.9-91.6).

Mortality was 0.4%.

Conclusion: Compared with literature, our population showed lower incidence of mortality, respiratory disorders and need for assisted ventilation, probably due to a great proportion of more mature infants.

[FIG 1]