receive lower amounts of macronutrients, especially protein and energy, compared with current recommendations, and show significant postnatal growth failure. Our observation of significant positive associations between macronutrient intakes and weight change implies that improved early nutrient intakes may be one way to prevent postnatal growth retardation in these infants.

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TIGHT GLUCOSE REGIMEN IN CRITICALLY ILL INFANTS

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Background and aims: Treating hyperglycemia with insulin in critically ill children results in improved outcome and has become standard practice in many PICU's worldwide. Infants have an increased risk of developing hypoglycemia. We evaluated the outcome of critically ill infants treated with a step wise nurse-driven tight glucose protocol.

Methods: Infants (0 - 28 days) treated with a tight glucose protocol during a 3-year period in a tertiary PICU were retrospectively analysed.

Results: 385 children were treated, 78 (21,3%) were infants and therefore included for analyses. Overall mortality was 24.4%. Normoglycemia (< 8 mmol/L) was reached within 4,5 hours (range 1 - 25) with insulin (median dose 50 mIU/kg/hr; range 10 - 450). Median duration of treatment was 24 hours (range 1 - 308), 71% of the infants were treated less than 48 hours.

Hypoglycemia ($\leq 2,2$ mmol/L) and severe hypoglycemia ($< 1,7$ mmol/L) occurred in 7 (9,0%) and 2 (2,6%) infants respectively, but did not lead to clinical symptoms. Two (22,2%) hypoglycemic and 17 (24,6%) non-hypoglycemic infants died. Hypoglycemia occurred more than once in one hypoglycemic infant, and in both infants with severe hypoglycemia. Blood glucose levels prior to insulin treatment, dose and duration of insulin therapy, time to achieve normoglycemia, the use of corticosteroids and clinical diagnoses did not differ between hypoglycemic and non-hypoglycemic infants.

Conclusions: Infants were successfully treated with a step wise nurse-driven tight glucose protocol with a low percentage of severe hypoglycaemia. Overall treatment was short.

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BREASTFEEDING IN DANISH NICUS

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Objective: To describe the conditions for breastfeeding in Danish NICUs, the structures, breastfeeding policies and practices for premature infants.

Method: A national survey was conducted in August 2009, all 19 Danish NICUs responded.

Results: The 19 NICUs had a mean of 17 beds; five NICUs had obstetric service. All NICUs could have some mothers staying overnight (mean 10 mothers). Only two NICUs had restrictions for parent's presence. Most NICUs had a breastfeeding policy and written guidelines for breastfeeding premature infants and milk expression. Milk expression was recommended to start within six hours after birth, and most NICUs encouraged mothers to double pump. Most NICUs had systematic breastfeeding training for the staff; but only 5 NICUs had a lactation consultant (IBCLC). All NICUs allowed the premature infants to suckle when they still had nasal CPAP. During transition from tube feeding to breastfeeding, the most common method for supplementation in all NICUs was tube feeding; only two NICUs would offer the infant bottle-feeding during transition. Half of the NICUs used test-weighting. The aim for most NICUs was to initiate skin-to-skin contact the first time the parents was in the NICU, and for most infants skin-to-skin contact continued 2-4 hours or up to eight hours a day.

Conclusion: The Danish NICUs gave high priority to breastfeeding reflected in policies for milk expression, supplementation, skin-to-skin contact and parent's presence in the NICU. The survey was first part of an ongoing national breastfeeding survey with expected participation of nearly 2.000 premature infants.