

## High Frequency Oscillatory Ventilation versus Synchronized Intermittent Mandatory Ventilation in Respiratory Distress Syndrome

I read the article by Singh, *et al.* with great interest [1]. However, I would like to point out few issues which need clarification.

First, out of 296 infants of respiratory distress syndrome (RDS) requiring continuous positive airway pressure (CPAP), a total of 150 infants required intubation for invasive ventilation and another 53 infants requiring intubation couldn't be randomized due to non-availability of designated ventilator. This means that there was a CPAP failure in 69% of the cases. Studies from India itself had shown a much lower CPAP failure rate of around 25 to 40% despite the use of surfactant in selected cases [2, 3]. This high failure rate of CPAP raises its own set of issues: how accurately was the definition of respiratory distress syndrome (RDS) being applied? What is the policy for surfactant administration in the unit? Are these findings generalizable to settings where the rate of CPAP failure is almost half?

Second, the authors have excluded the infants which were off ventilation within 24 hours after randomization. This is despite of the fact that oxygenation index at 1 and 6 hours of ventilation was also the part of primary outcome. These infants constituted more than one fourth of the total participants in the trial and their exclusion could have resulted in biased results. What is the reason of their exclusion and how were they adjusted in the final analysis needs clarification?

Third, the information regarding the distribution of various brands of surfactant used, their doses and the total number of times the surfactant was administered in both the groups is lacking. All these factors affect the  $\text{FiO}_2$ , oxygenation and the ventilatory requirement especially in the first 24 hours of initial treatment [4,5]. Moreover, text mentions that the lower tidal volumes were targeted in synchronized intermittent mandatory ventilation (SIMV) group but its exact range in mL/kg is missing.

NEERAJ GUPTA  
Assistant Professor  
Department of Neonatology  
Maulana Azad Medical College  
New Delhi 110 002, India.  
[neerajpgi@yahoo.co.in](mailto:neerajpgi@yahoo.co.in)

## REFERENCES

- Singh SN, Malik GK, Prashanth GP, Singh A, Kumar M. High frequency oscillatory ventilation *versus* synchronized intermittent mandatory ventilation in preterm neonates with hyaline membrane disease: A randomized controlled trial. *Indian Pediatr.* 2012;49:405-8.
- Koti J, Murki S, Gaddam P, Reddy A, Reddy MD. Bubble CPAP for respiratory distress syndrome in preterm infants. *Indian Pediatr.* 2010;47:139-43.
- Saxena A, Thapar RK, Sondhi V, Chandra P. Continuous positive airway pressure for spontaneously breathing premature infants with respiratory distress syndrome. *Indian J Pediatr.* 2012 Mar 7. [Epub ahead of print]
- Speer CP, Gefeller O, Groneck P, Laufkötter E, Roll C, Hanssler L, *et al.* Randomised clinical trial of two treatment regimens of natural surfactant preparations in neonatal respiratory distress syndrome. *Arch Dis Child Fetal Neonatal Ed.* 1995;72:F8-13.
- Ramanathan R, Rasmussen MR, Gerstmann DR, Finer N, Sekar K. North American Study Group. A randomized, multicenter masked comparison trial of poractant alfa (Curosurf) *versus* beractant (Survanta) in the treatment of respiratory distress syndrome in preterm infants. *Am J Perinatol.* 2004;21:109-19.

## REPLY

We thank the authors for their interest in our study [1]; 296 infants assessed for eligibility were cases having respiratory distress syndrome and requiring ventilation; of these, 150 infants were randomized. The remaining 146 infants could not be included because either they were excluded as per exclusion criteria, or the designated ventilator was not available, and thus, it does not reflect CPAP failure rate. The diagnosis of hyaline membrane disease was made as per working definition of NNPD of India, which includes clinical parameters, and chest radiology or negative gastric aspirate shake test.

Oxygen index (OI) was the primary outcome and it was measured at 1, 6 and 24 hours. Since significant drop-out was expected and we intended to look for longitudinal trend in OI over time on first day of ventilation, it was decided *a priori* to conduct analysis only on those infants who complete initial 24 hrs of ventilation. Moreover, the proportion of subjects who could not complete initial 24 hrs of ventilation after randomization were quite similar in both the groups (HFOV: 25.8%; SIMV: 27.3%).

As per our unit policy we administer surfactant to preterms with gestational maturity < 34 wks having respiratory distress due to HMD at earliest possible hours; however, it is used in only those who can afford it. We use Curosurf (porcine minced) for infants weighing <1000 g and Survanta (bovine minced) for those >1000 g.

None of our patients in either group had received multiple doses of surfactant. Detailed analysis of patients receiving surfactant was not a stated objective; however, the major baseline characteristics were similar in both the groups. It was aimed to keep the tidal volumes lower by using lower PIP and optimal PEEP to maximally recruit lungs in synchronized intermittent mandatory ventilation (SIMV) group; however, tidal volume was not measured.

**SN SINGH**  
Associate Professor;

Department of Pediatrics,  
Chhatarpati Shahu Maharaj Medical University,  
Lucknow 226 003, Uttar Pradesh, India.  
drsn.singh@rediffmail.com

## REFERENCES

1. Singh SN, Malik GK, Prashanth GP, Singh A, Kumar M. High frequency oscillatory ventilation *versus* synchronized intermittent mandatory ventilation in preterm neonates with hyaline membrane disease: A randomized controlled trial. Indian Pediatr. 2012;49:405-8.

## Early term – Continuing Conundrum of Immaturity

In the past decade, the focus in newborn care has been on the concept of “late preterm”. The short term and long term complications of preterm birth between  $34^{0/7}$  and  $36^{6/7}$  weekly have become well recognized. Most doctors and patients assume that once “term” gestation is reached; the outcome is uniformly optimal [1]. However recent reports have highlighted the differential outcomes even in term infants born before 39 weeks and after. Respiratory distress, need for ventilation, hypoglycemia, sepsis, and NICU admissions, are higher in the infants born between  $37^{0/7}$  and  $38^{6/7}$  as compared to after 39 weeks [2-3]. Tita, *et al.* [4] determined the risk of adverse outcomes such as mechanical ventilation, newborn sepsis, hypoglycemia, admission to the neonatal ICU, and hospitalization for 5 days or more to be increased by a factor of 1.8 to 4.2 for births at 37 weeks and 1.3 to 2.1 for births at 38 weeks compared to 39 weeks. Long term neurodevelopmental outcomes and need for special education has also been found to be higher [5]. We reviewed our 2011 annual data (**Table I**) and compared the outcomes in 3 groups: late preterm ( $34^{0/7}$  to  $36^{6/7}$  weeks), 37 weeks and 39 weeks. A delay of 2 weeks after 37 weeks added 300 g to the weight and significantly reduced NICU admissions, hypoglycemia and jaundice requiring phototherapy.

This heterogeneity in outcomes in the group of “term” births has generated 2 categories: “early term” births ( $37^{0/7}$  and  $38^{6/7}$  weeks) and “full term” births ( $39^{0/7}$  to  $41^{6/7}$  weeks). This new definition of “early term” emphasizes the continuing immaturity and potential for adverse outcomes. Though spontaneous onset of labor before “full term” or indicated delivery due to maternal-fetal complications are inevitable, the growing menace of

**TABLE I** NEONATAL OUTCOMES BY GESTATIONAL AGE

	34-36wk (n=287)	37wk (n=329)	39wk (n=633)
Mean birthweight (g) <sup>\$</sup>	2279	2769	3024
LSCS (%)	48.8	33.4	26.7
NICU admission (n)%*	46.3 (133)	18.2 (60)	12.9 (82)
Hypoglycemia (n)%#	11.5 (33)	4.5 (15)	1.7 (11)
Need for phototherapy (n)%* <sup>44.6 (128)</sup>	25.8 (85)	19.7 (125)	
Respiratory distress (n)%*	13.4(38)	3.6 (12)	3.6 (23)

\* Comparison between morbidities at gestational age 37 weeks and 39 weeks; \*P<0.05; #P<0.05; <sup>\$</sup>P<0.005.

delivering high risk mothers early – as soon as term gestation is reached – needs to be limited. As recommended, induction or scheduled cesarean section without any obstetric reason should be after 39 weeks. This has even become accepted as a quality indicator of obstetric care.

**SUMAN RAO PN AND SWARNAREKHA BHAT**

Department of Neonatology,  
St. John's Medical College Hospital,  
Bangalore 560 034, India.  
raosumanv@gmail.com

## REFERENCES

1. Reddy UM, Bettegowda VR, Dias T, Yamada-Kushnir T, Ko C, Willinger M. Term pregnancy: A period of heterogeneous risk. Obstet Gynecol. 2011;117: 1279-87.
2. Balit JL, Greory KD, Reddy UM, Gonzalez-Quintero VH, Hibbard JU, Ramirez MM, *et al.* Maternal and neonatal outcomes by labor onset type and gestational age. Am J Obstet Gynecol. 2010;202:245.e1-12.
3. Wilmink FA, Hukkelhoven CW, Lunshof S, Mol BW, van der Post JA, Papatsonis DN. Neonatal outcome following elective cesarean section beyond 37 weeks of gestation: a 7-year retrospective analysis of a national registry. Am J Obstet Gynecol. 2010;202:250,e1-8.