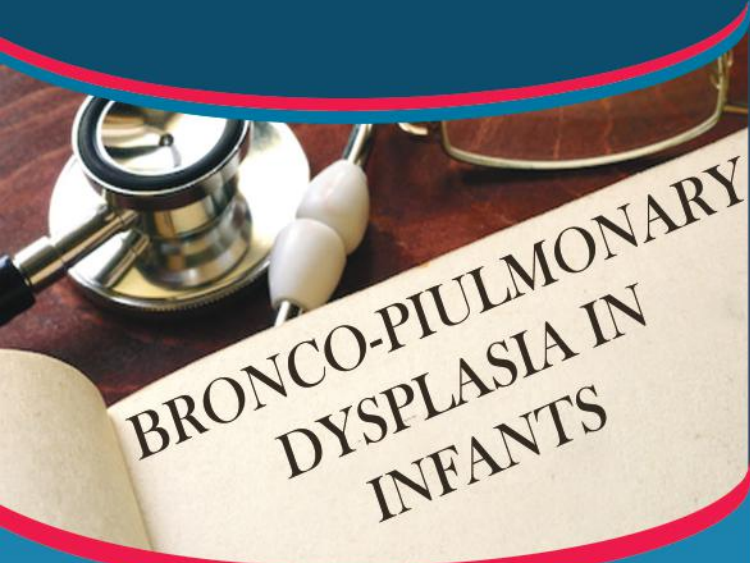




Bronco-pulmonary Dysplasia In Infants



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Increased inhaled oxygen can hurt risk of retinopathy, pulmonary edema, and inflammation.

Most infants with moderate fluid restriction are managed up to 140 to 150 mg per kg of body weight per day.

Although diuretic therapy may improve lung condition in the short term, there is no evidence that diuretic therapy improves clinical outcomes. The use of diuretics leads to serum electrolyte abnormalities such as hyponatremia and hypokalemia.

Adequate food intake is critical for lung growth, alveolar development, surfactant production, and protection against infections. In infants with bronco-pulmonary dysplasia, lean body mass is reduced, indicating inadequate intake.

Treatment with corticosteroids also increases body fat and decreases protein, thereby altering the composition of weight gain.

Although lipids are considered a vital part of supplying essential fatty acids and meeting energy needs, the role of lipid administration is still controversial.

Lipids are given in small amounts; because they can increase the risk of kernicterus in these babies.

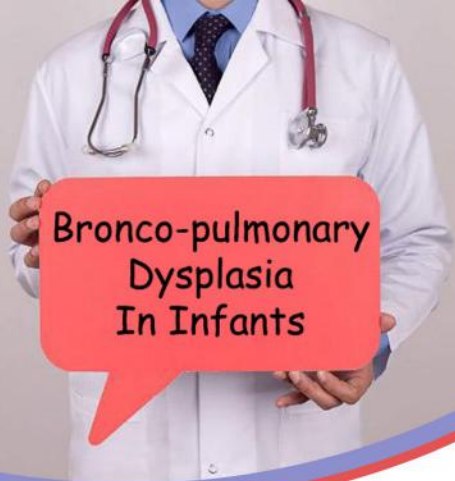


Compared to carbohydrates, lipids lead to lower carbon dioxide production, and although high-fat formulas do not significantly alter adult respiration, infants receiving lean formulas reduce carbon dioxide production and improve respiration. Has found. It is recommended to consume 40 to 55% of calories from fat.

Sodium and potassium depletion is seen in infants with bronco-pulmonary dysplasia treated with diuretics. Mild sodium and chloride deficiencies are predictable because sodium administration renders diuretics ineffective.

Decreased bone mineralization is also seen in these infants. Urinary calcium loss is also increased by prescribing corticosteroids and diuretics.

Premature osteopenia is also common in infants with bronco-pulmonary dysplasia due to nutritional deficiencies of calcium and phosphorus.



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The treatment regimen for bronco-pulmonary dysplasia in infants

The managerial approach should minimize the possibility of further injury and at the same time provide a favorable environment for growth and recovery.

Symptoms of bronco-pulmonary dysplasia

The symptoms of bronco-pulmonary dysplasia vary depending on its severity. The most common symptoms of bronco-pulmonary dysplasia are:

- ▶ Rapid and continuous breathing
 - ▶ Hard breathing
- ▶ Wheezing (soft whistling as soon as the baby breathes)
 - ▶ Difficult feeding
- ▶ Recurrent lung infections that may require hospitalization.

▶ In patients with bronco-pulmonary dysplasia, there is a decrease in pulmonary reception capacity (compliance) and the need for respiratory support.

▶ The findings show that the effects of the fetal inflammatory response play a role in pulmonary growth and also play a significant role in the development of bronco-pulmonary dysplasia.



Periodic efforts are being made progressively to separate infants from assisted ventilation. Prolonged ventilation is associated with laryngeal injury and subglottic stenosis, especially in infants requiring multiple intubations.

Suctioning should be limited to the time required, as it is associated with tracheal and bronchial damage.

The use of supplemental oxygen in these patients is controversial due to the need to treat hypoxia on the hand and to avoid contact with excess oxygen on the other.

Continuous pulse oximetry is used to monitor oxygenation; blood gas sampling is used periodically to monitor the PH and relative pressure of arterial carbon dioxide.