Neonatal Abstinence Syndrome with Dr. Karen D'Apolito

Questions and Answers

Q: Brigham : How do you decipher who's cord gets collected and tested? Sometimes you don't know about drug use ahead of time. Would you need consent?

A: That is true. Many places are just cutting the cord and keeping it just in case. It should be refrigerated.

Q: Dannielle Towey: Do you score sleep 1 hour after feed and based on the sleep prior to feeding?

A: You score from one scoring interval to another. So you would score from one feeding to the next. In that 3 hour interval how much did the baby sleep: < 1 hour after the feeding; <2 hours or < 3 hours.

Q: Marcia Fisher: How is scoring accomplished? Are babies kept in the nursery? Is scoring to be done by RNs?

A: Yes. Scoring is done by the RN's. To be reliable in using the tool they would need to be tested to reliability with the instrument. I will discuss this in our next webinar (Friday, August 3, 2012). The babies are kept in the nursery after the mother is discharged if the baby needs observation or treatment.

Q: Heather Dickinson from Sutter Coast Hospital: Who uses sheep skin?

A: Karen: Not too many people use sheep skin any longer but some places do.

A: JaTonya White from IU Health Methodist: We do not. What about modeling crib safety and safe sleep for these high risk families?

A: Beth Huizinga from Grand Rapids, MI: We do not as it is contraindicated by safe sleep guidelines

A: Britta Anderson from North Dakota: During the acute stage for the sheepskin and boundaries then it is removed once the treatment is working

A: Jean Brownlee from IN: Use containment products until dosing is weaned to q12 hr. Then use safe sleep practices.

A: Jan Hunter from TX: Might depend on how long NAS babies are hospitalized? Ours often stay 6-12 weeks (!!); we use Z-Flo (comfort, proprioceptive pressure, boundaries) until closer to DC

A: Deborah Eveland from Kaiser Oakland NICU: Updated AAP guidelines: Pediatrics 2012; 129:2 e540-e560; published ahead of print January 30, 2012, doi:10.1542/peds.2011-3212

A: Susan Bowles from Oceanside CA: We started using the Z-flow as well and have seen a big difference especially in sleep- we do transition closer to D/C

Q: Brigham : What literature did you base your treatment protocol on (ie. where to start and how to increase/wean)?

A: The weaning protocol came from the Child Health Network from Canada. There are many different ways to wean morphine. Typically it is 0.05mg/kg/dose.

Q: Kathleen Smith from Suisun City, CA: We used to use a rocking warmer bed (Nature's Cradle) with our withdrawing babies. Our unit broke and we've learned it's been taken off the market. Does anyone have a resource for a similar item. The slow, continuous rocking really seems to help.

A: In terms of Nature's Cradle, you might want to take a look at my dissertation study which tested the bed to see if it reduced signs of withdrawal. It was published in Maternal Child Nursing in 1998.

A: Beth Huizinga from Grand Rapids, MI: Kathleen Smith - check into the Mama Roo - a great device

A: I have seen Mama Roo. We just need to be sure it is not over-stimulating (Karen).

Q: Shareen Taylor: Can a level 1 hospital initiate morphine?

A: Yes, if the nurses are trained.

Q: Dolly Verdon from Abington,PA: Do you see tachycardia with your population?

A: Tachycardia is not one of the signs of withdrawal that has been identified in the literature and we don't see that clinically. What we do see is tachypnea.

Q: Lisa Fischer from Mountain View Hospital: When would you add phenobarbital in?

A: Typically it would be added if you have reached the maximum level of oral morphine. Many places are using Clonidine rather than phenobarbital.

Q: Julie Swanson from St. Luke's Children's Hospital: How do you define "term" for use of the scale?

A: 37 weeks or greater.

Q: JaTonya White from IU Health Methodist: How do you score infants who have matured beyond the age recommendation for the Finnegan tool?

A: Unfortunately we don't have a tool for them. The goal is to get the baby treated early so they can be discharged from the hospital within a period of time so they don't outgrow the tool. As long as you can accurately complete all items of the tool it can be used. Otherwise, we do not have an accurate tool.

Q: Diane Hitchens from PRMC: When do you score babies before or after the feeding?

A: It is best to score the babies before the feeding. The hope is that the baby will fall asleep with the feeding. If this happens, I would not suggest waking the baby up to do a scoring. So, stick with scoring before the feeding. Typically, the scoring is done, vital signs taken, medication given and then the baby is fed. Hopefully the baby will sleep for <3 ours until it is time for the next scoring interval.

Q: Pauline Hayes from University of Louisville Hospital: If you score before feeds, how do you differentiate between hunger and withdrawal? We score after the feed, prior to sleep. We also never score a sleeping infant.

A: If you consistently do the score before a feeding that provides a constant factor that does not affect the scoring. If you do think the baby is really hungry you can give the baby some formula before you score them and then finish the feeding after the scoring, etc. I have found that these babies have a tendency to be over fed. I suggest having the physician figure out how many cc/kg/day the baby needs for growth and that is what the baby gets every 3 hours. Having this type of control will eliminate the hunger factor since the baby will be getting what they need.

Q: Brigham : How do you decipher whose cord gets collected and tested? Sometimes you don't know about drug use ahead of time. Would you need consent?

A: No, you don't need a consent to get the cord. If you suspect a baby has been exposed, go ahead and get a urine or meconium. The cord would fall into this same category. I suggest getting a good history on the mother. That will help to determine if you should collect the cord. Some places are just getting it so they have it if they find out the mother used drugs during pregnancy.

Q: Irene Hurst from Pacific Grove, CA: Are there tools you can recommend for use with late preterm infants?

A: I would use the same tool. It would apply to those babies as well.

Q: Katherine Robbins from SSM Cardinal Glennon Childrens Hospital: What about clonipine and buprenophrine treatments for babies in the NICU?

A: Well, studies are being done with these drugs. We don't have enough information right now to recommend these for treatment. I know we will be hearing more about these drugs in the future.

Q: Karen P Sandhoff: Do you recommend breastfeeding the NAS infant?

A: Yes, if the mother is in a methadone treatment program and she is following her program she can definitely breast feed. It would be important to be sure she was not taking any other drugs so a random drug screen on the mom or breastmilk might be needed.

Q: Cathleen Carter from Fort Worth: What are the symptoms months later for the infants treated with Methadone? What would we teach the mother to look for?

A: There can be sub-acute signs such as fussiness, irritability, difficulty sleeping . These are the things you would see.

Q: Jan Hunter from Tx: Our irritable babies probably have excessive holding and comforting, as both baby and staff are miserable. Seems to falsely deflate NAS score? And how to tell when a longer-term weaning baby is just spoiled or still in distress?

A: My feeling is that if the staff or mother can hold the baby and they are quieted, it is fine to score the baby. What this says is that the baby can be comforted and when they are comforted the baby has better control over their signs of withdrawal. I would not think about spoiling a baby who is experiencing withdrawal. If the baby is being treated appropriately and their signs of withdrawal get under control the baby will not require so much holding.

Q: Heather Dickinson from Sutter Coast Hospital: Can we get the slides or a link sent to us?

A: All links for this webinar are posted at http://www.dandlelion-webinars.com/april-2012-resources/