Follow up

1. **Hospital** outcome for babies with RDS should be monitored as part of routine data collection. The BAPM dataset is recommended as the minimum information to collect about all babies who require admission to a neonatal unit[1].

2. Each unit should have a defined protocol for follow up and close liaison with child development teams in the locality, and in addition should ascertain the later health status of such survivors on a local and geographical basis. Standard definitions of severe disability are available for two year old children[2], including measures of respiratory disability, which should be monitored and reported in annual reports[3].

3. ***After discharge*** most children with RDS will have no long term sequelae from their neonatal respiratory illness, unless they have developed chronic lung disease. In those born very preterm, RDS is associated with an increased frequency of neurological sequelae because of an association with acquired brain injury. Where there have been neurological concerns, any child should be followed as an outpatient.

4. ***Children who have developed CLDI,*** in contrast, are at particular risk of continuing respiratory morbidity with persisting symptoms of cough and wheeze[4]. They have a high chance of readmission and a need for further mechanical ventilation after discharge home.

5. Children with CLDI should receive close monitoring of their nutritional status and those requiring home supplemental oxygen therapy will require community nursing support.

6. Respiratory syncytial virus infection poses a particular risk in babies with CLDI, and consideration should be given to prophylaxis during the season of maximal risk. The JCVI currently recommends immuno-prophylaxis for babies on home oxygen[5], although previously only babies receiving supplemental oxygen at home were frequently given RSV-specific immuno-globulin.

7. Routine immunisation with pneumococcal vaccine and seasonal influenza vaccine are also recommended.

8. Parents who smoke should be advised to cease smoking as this will exacerbate respiratory illness in their child.

9. It is good practice to follow up all very preterm children for at least two years, in order to monitor neurodevelopmental and respiratory progress[3]. This is independent of the occurrence or severity of RDS because of the risk of developmental problems. As a minimum this includes babies born at 30 weeks of gestation or less and babies <1000g birthweight.

References

1. BAPM. The BAPM Neonatal Dataset. London: British Association of Perinatal Medicine; 1996.
2. Report of two working groups:. Disabilty and Perinatal Care: measurement of health status at two years. Oxford, England: National Perinatal Epidemiology Unit; 1995.
3. BAPM. Standards for Hospitals providing Intensive and High Dependency Care. London: British Association of Perinatal Medicine; 2001.
4. Dezateux C, Stocks J. Lung development and early origins of childhood respiratory illness. Br Med Bull 1997;53(1):40-57.
5. Joint Committee on Vaccination and Immunisation. Annual report. London: Department of Health; 2003.