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Neonatology

BLOOD GAS EXCHANGE AND NEONATAL ERYTHROBLASTOSIS

The authors evaluated neonatal cardiorespiratory function (Pa_{O_2} and *p*H) and hematologic status in 61 premature infants with moderate-to-severe erythroblastosis fetalis. The data indicate that mortality among severely erythroblastotic infants was influenced by presence of hydrops, severity of the anemia, presence of asphyxia at birth, and rate of recovery from asphyxia. Death was due to progressive cardiorespiratory failure with pathologic changes characteristic of hyaline membrane disease, occasionally complicated by pulmonary or generalized hemorrhage. The data suggest that the pathophysiology is initiated by acute intrapartum asphyxia, possibly superimposed upon chronic mild asphyxia with prematurity and anemia as additional predisposing factors. The infant with hydrops is particularly prone to develop the respiratory distress syndrome.

Asphyxia, defined as a combination of hypoxemia and hypercarbia, is invariably associated with metabolic acidosis. Hypoxemia and acidosis result in pulmonary vasoconstriction and decreased pulmonary blood flow, a factor implicated in the pathogenesis of the respiratory distress syndrome.

The data appear to be in conflict with many of the already published findings concerning this problem. Although previous findings suggest that congestive heart failure is the principal cause of death in the severely erythroblastotic infant, studies like the present one emphasize the need for early recognition and treatment of respiratory distress syndrome. (*Phibbs, R. H., and others: Cardiorespiratory Status of Erythroblastotic Infants. I. Relationship of Gestational Age, Severity of Hemolytic Disease, and Birth Asphyxia to Idiopathic Respiratory Distress Syndrome and Survival, Pediatrics 49: 5–16, 1972.*) EDITOR'S COMMENT: Although a most interesting study, this paper epitomizes the perpetuation of an unexplained dichotomy: the congestive heart failure (CHF) and the respiratory distress syndrome are distinct clinical entities. Perhaps the failure to recognize that the child with CHF deserves therapy similar to that needed for respiratory distress, and *vice versa*, may still be responsible for the high mortality in both groups. For example, how often has right-sided heart failure been recognized (and treated) in the presence of RDS?