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FACTORS RESPONSIBLE FOR MATERNAL DEPRESSION AND ITS EFFECT ON GROWTH VELOCITY

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Objectives: In this study we investigeted various factors that might be responsible for maternal depression and also the efficacy of maternal depression on growth velocity of preterm infants.
Methods: Fortytwo preterm infants and their mothers were prospectively enrolled in the study.Mothers were assessed with "BECK DEPRESSION INVENTORY" at time of discharge. A score of > 17 was accepted as maternal depression. Depressive mothers were compared with non depressive on the basis of infant (gestational age, birth weight, duration of hospitalization, duration in NICU, type of feeding, initiation of full enteral feeding) and maternal – familial factors (maternal age, parent's education economic status, parity, multilple gestation, marriage status).Growth velocity, on the basis of weight gain, increase in head circumference and height were compared between two groups at 1, 2, 3, and 4 months of discharge.
Results: Twentythree mothers (%54,7) were diagnosed as having depression. None of the infant and maternal factors,other than preterm delivery,were found responsible for maternal depression($p>0,05$).On follow-up of growth velocity,the rate of weight gain was found lower in infants of depressive mothers in the first month of their discharge($p<0,05$).However no significant difference was detected between growth rates of two groups at 2, 3 and 4 months.
Conclusion: We observed that preterm infants with maternal depression had greater risk of inadequate weight gain especially during the first month of their discharge.So, follow-up programs should incorporate support services for depressive mothers of these infants and frequent infant nutrition monitorization should be done to minimize undesirable effect of maternal depression.

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DRUG-INDUCED HYPERSENSITIVITY SYNDROME IN A PREMATURE INFANT

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Background: Drug-induced hypersensitivity syndrome (D-IHS) has been reported to occur mostly due to aromatic antiepileptic drugs. The syndrome has been described in children from infancy to adolescence but has not been reported in newborn infants. In this article we report a premature infant who developed D-IHS due to phenytoin and was treated successfully.
Case: A 1170 g preterm male infant was born by cesarean section at 27 weeks of gestation. On the third day of life he developed tonic seizures due to grade III intraventricular hemorrhage. Intravenous phenobarbital therapy was initiated for convulsions. On the fifth day, although a therapeutic blood level of phenobarbital (35.6 µg/mL, 15-35 µg/mL) has been reached, he again had convulsions. Intravenous phenytoin was added to the anticonvulsant therapy with a loading dose of 10 mg/kg and maintenance dose of 5 mg/kg/day in two doses. On the 18th day of life, while he had no any other medications except intravenous fluids, total parenteral nutrition, phenobarbital and phenytoin he developed a patchy, erythematous rash after the administration of daily phenytoin dose. Accompanying physical examination findings were a fever of 38.5 °C (axillary) and 39.2 °C (rectal), moderate facial, periorbital and marked foot edema. (Figure 1 and 2). Leukocyte count was 24700/mL and leukocyte differential was normal except slightly elevated eosinophils (3%). The baby was diagnosed as D-IHS due to phenytoin and phenytoin was discontinued. He was treated with 0.1 ml/kg of an epinephrine solution of 1:10.000 concentration and 0.5 g/kg dexamethasone intravenously. The rash and the edematous extremities turned to normal within 48 hours and did not develop again.
Conclusion: D-IHS can be seen in newborn infants and skin rashes in a newborn infant who is receiving an anticonvulsant drug should alert the physician for the syndrome.

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