Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 6439

**Please reply to:**
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10 December 2020

**Freedom of Information Act 2000**

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Cooling/Therapeutic Hypothermia Protocol.

*You asked:*

*We require sight of the Cooling/Therapeutic hypothermia protocol in the neonatal and/or Special Care Baby Unit at Maidstone & Tunbridge Wells NHST, that was in force in November 2015. We are merely requesting this to provide us with knowledge in accordance with the act.*

Trust response:

In 2015 as far as we are aware the Trust were using the following guideline in line with the TOBY trial A and B inclusion criteria: available at https://bmcpediatr.biomedcentral.com/articles/10.1186/1471-2431-8-17

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# Maidstone & Tunbridge Wells NHS Trust

Department of Paediatrics

## The management of suspected Perinatal asphyxia

1. Commence fluids at 40 ml/kg/day. Review fluid requirements in light of subsequent progress. Monitor urine output and weight.

2. If the baby is ventilated, insert UAC/UVC and aim to maintain $PaCO_2$ between 4 and 6 kPa.

3. Maintain the mean arterial blood pressure at or above 40 mmHg. Target mean BP would be higher in babies with suspected pulmonary hypertension. Slightly lower pressures are acceptable for babies less than 35 weeks gestation, but discuss with the duty consultant.

4. Cerebral function monitoring (CFM) should be done if any suspicion about clinical or subtle seizures. All sick asphyxia babies should have CFM monitoring to look at their background activity and possible seizures.

5. If the baby develops clinically evident convulsions, use phenobarbitone as first line treatment. Give a loading dose of 20 mg/kg iv over 20 minutes, then 5 mg/kg once daily as maintenance treatment if necessary

6. Treat hypoglycaemia (blood glucose <2.6 mmol/l) and hypo-calcaemia (serum calcium <1.6 mmol/l) if necessary. Avoid hyperglycaemia (blood glucose >8 mmol/l)

7. All babies (36 weeks and above) with perinatal asphyxia should be assessed against criteria A and B for cooling. This should be discussed with consultant on call and the assessment should be documented in baby notes.

8. Aim to maintain normal body temperature, approximately 36.5 $^{o}$C, unless the baby fits the criteria for cooling, in which case, refer to the Network guidelines for therapeutic hypothermia. Passive cooling should be commenced as soon as possible (maximum 6hrs of age), and arrangements made for transfer to a tertiary NICU.

9. Babies undergoing cooling should have their Thomson score done for assessment and monitoring. Babies undergoing cooling treatment do not necessarily need to be ventilated.

10. Cranial USS should be done to look for evidence of cerebral oedema and/or haemorrhage. (do not over diagnose cerebral edema, slit ventricles could be normal in term babies). Measure resistivity index in MCA and ACA if you can.

11. If antibiotics are commenced, use Cefotaxime 25mg/kg BD, in place of the usual Benzylpenicillin and Gentamicin

Corticosteroids and mannitol are not routinely used in the treatment of birth asphyxia.

Total body cooling: see cooling protocol folder in NNU.