

- There are many potential causes of collapse in a neonate – see boxes
- Many of these will require time-critical transfer for definitive care
- This guide aims to assist in the stabilisation & transfer of these infants

Potential Underlying Diagnosis

The boxes below are an aide memoire for the most likely causes of neonatal collapse. Whilst not designed to be exhaustive, they highlight many of the cardinal features of some of the most common presentations.

Recognition of Neonatal Shock

Classical findings in neonates are those of a 'cold shock' / elevated SVR state

- Tachycardia
- Poor perfusion: pallor, mottled/cool peripheries, weak pulses, ↑Cap refill T.
- ↓ level of consciousness / lethargy / irritability
- **Hypotension is a late sign. Do not be reassured by normal/high BP**

Other findings may include:

Apnoea, tachypnoea, hypothermia and hypoglycaemia

An APLS based structured ABCDE approach is recommended throughout with reference to the white boxes to assist with differential diagnosis & workup

Airway & Breathing

- Ensure airway patency is maintained – if apnoeic or obstructed breathing - recommend urgent anaesthesiology review
- Recommend a low threshold for intubation in the event of recurrent apnoea. **Resuscitate before intubation** wherever possible to avoid CVS collapse on induction of anaesthesia. See Intubation & Ventilation QR overleaf for advice
- Grunting/Kussmaul breathing may be 2nd to metabolic acidosis – check Gas
- Aim to **maintain O2 sats between 94-98%**. Hyperoxia can be harmful. Titrate FiO₂ diligently.
- If there is work of breathing associated with hypoxia start high flow O₂ nasal cannula at 2L/Kg/min
- If cyanotic heart lesion is suspected discuss urgently with cardiology in CHI. O₂ saturation target may need to be amended to 75-85%

Circulation

- Obtain IV access – very low threshold for using IO. PIV attempts x2 only
- Unless signs of heart failure – **Give 10ml/kg Hartmann's via IV push**
- Reassess +/- repeat bolus up to 40ml/kg → fluid refractory shock. Stop boluses if signs of deterioration/heart failure - may need early inotropes
- **Prepare adrenaline** as first line inotrope if signs of heart failure or >40ml/kg fluids given & still shocked. Commencement under direction of PICU. **Prepare noradrenaline** once adrenaline commenced for 2nd line use.
- Aim for iCa (on blood gas) of >1mmol/L - replacement dose overleaf

Start **Dinoprostone** (prostin) if concern for duct dependent cardiac lesion:

- If shocked, start at 10-20nanograms/kg/min & **discuss with cardiology** for ongoing support and discussion re dosing (may need 50-100ng/kg/min)
- Hypotension & apnoeas are common with higher doses - prepare for both
- Likely to need intubation if being transferred on >15nanograms/kg/min

Administer empiric antibiotics to all infants:

Cefotaxime 50mg/Kg + Gentamicin 5mg/kg + Benzylpenicillin 100mg/kg as per Clinibee guidance. **Do not delay administration** to obtain blood cultures.

Don't ever forget the glucose!

- NGT recommended – leave open on bile bag for drainage on transfer
- 100% Maintenance IVF with 0.9% NS + 10% Dextrose recommended
- Check blood glucose regularly – prone to hypoglycaemia
- Treat hypoglycaemia with **3ml/kg Dex 10%** AND inc. dextrose conc. in fluids

First Line Investigations

- CXR +/- PFA if concerns re intrabdominal pathology
- ECG if tachycardic / concerns re arrhythmia
- Point of care ultrasound to assess ventricular function if trained personnel available. (Formal paediatric ECHO if available)
- Send (in order) **VBG / Culture / U&E / LFT / NH3 / FBC / Coag / CRP**
- Urine C&S / viral NPA recommended

Sepsis

Should always be presumed

- ↑ or ↓ HR / ↑ RR or apnoeic
 - Low/high temperature
 - Pale & mottled, cool peripheries
 - Elevated/normal lactate
- Add acyclovir** if coagulopathy/abnormal LFTs/ signs of encephalitis or a history of Herpes Simplex contact

Cardiac

↑ HR / >220 → ?SVT – immediate ECG

Murmur / cardiomegaly / abnormal heart shape on CXR

Duct dependent cardiac lesion:

- Hypoxia unresponsive to O₂ / Reduced or absent femoral pulses / 4 limb BP/Sats differential
- If pink with shock + poor pulses – possible HLHS

Myocarditis/cardiomyopathy

- Arrhythmias / pulmonary oedema / +liver edge/ no response to fluid bolus / cardiomegaly on CXR

ALCAPA: Hx of distress/dyspnoea with feeds/ ↓wt gain

Obstr.TAPVD: Shock + cyanosis. 'Wet lungs' on CXR

Discuss with cardiology if cardiac lesion suspected

Inherited Metabolic Disorder/ Toxins

Reduced GCS, Seizures, Vomiting

- Marked acidosis + ↑ ketones - ?Organic Acidaemia
- Resp Alkalosis + ↑ Ammonia - ?Urea Cycle defect
- Hypoglycaemia + ↓/no ketones - ?Fatty acid Oxid. D

Stop all feeds. Start 10% Dex in maintenance fluids

Send urgent **Ammonia** + blood gas + ketones

Discuss with metabolic team if IMD suspected

Consider naloxone if history of methadone use in home

Send urine for toxicology screen

Endocrine

Shock + Hypoglycaemia → Consider hypothalamic – pituitary – adrenal axis conditions e.g.

Congenital Adrenal Hyperplasia:

- Hypoglycaemia (often refractory to dextrose bolus)
- Shock refractory to fluid resuscitation
- ↓Na / ↑K (salt wasting crisis)

Treat shock + hypoglycaemia (**3ml/kg Dex 10%**)

Send serum cortisol/17-OHP if possible

Give 10mg hydrocortisone IV by slow push

Discuss with CHI Endocrinologist if any suspected

Trauma / Surgical

Abusive head trauma/intracranial bleed:

- Focal neurology/bulging fontanelle/abnormal pupils
 - Seizures/encephalopathy
 - Cushing triad - ↓HR/ ↑BP/ irregular respirations
- Give 1mg vit K if not given at birth
CT brain if stabilised sufficiently to tolerate

Abdominal surgical emergencies: Volvulus/NEC

Abdo distension/bilious vomit/blood in stools

NPO + NGT + PFA + contact surgeons in CHI

Respiratory Support tools



High Flow set-up
<25L/min flow



Pre-Intubation
Checklist



Intubation Equipment
Sizing Guide



Invasive Ventilation
setup <15Kg



Paediatric Intubation &
Ventilation Guide

Critical Infusions

These infusions are a guide to those commonly used. Choice of medication, dose and route lie with the medically responsible clinician



NON-SCI
infusion table



CHI - SCI
infusion table



All medication dosing/route information can be found on the CHI 'Clinibee' app



CHI GUIDELINE FOR DOSING, PREPARATION AND ADMINISTRATION OF DINOPROSTONE INFUSION FOR NEONATES

CHI SCI Standard Concentrations PICU/Theatre: CONTINUOUS INFUSIONS AND LOADING DOSES (Version 4 Feb 2019)

Rate Calc (mL/hour) = $\left\{ \frac{\text{Required Dose} \times \text{Default Rate (ml/hour)}}{\text{Default start dose}} \right\}$

Drug	Category	Weight Band	SCI (Normal)	Diluent	Usual Dose Range	Default Dose and Rate Calculator <i>All Weights in kg - rounding can occur</i>	
						Default Start Dose	Default Rate (mL/hr)
Adrenaline	Cardio	All ≤5kg >5 - ≤10kg	1mg/50mL 3mg/50mL	Glucose 5%w/v NaCl 0.9%w/v	0 -0.1microgram/kg/min	0.05microgram/kg/min	0.15 x Wt 0.05 x Wt
Noradrenaline	Cardio	All ≤5kg >5 - ≤10kg	1mg/50mL 3mg/50mL	Glucose 5%w/v NaCl 0.9%w/v	0 -0.1microgram/kg/min	0.05microgram/kg/min	0.15 x Wt 0.05 x Wt
Milrinone Maintenance	Cardio	All ≤5kg >5 - ≤10kg	5mg/50mL 10mg/50mL	Glucose 5%w/v NaCl 0.9%w/v	0.25-0.75 microgram/kg/min	0.5microgram/kg/min	0.3 x Wt 0.15 x Wt
Dinoprostone	Cardio	All ≤5kg	50microgram/50mL	Glucose 5%w/v	5-10nanogram/kg/min	5 nanogram/kg/min	0.3 x Wt
Dinoprostone (High Dose)	Cardio	All ≤5kg	400microgram/50mL	Glucose 5%w/v	As per cardiologist	40 nanogram/kg/min	0.3 x Wt
Midazolam	CNS	≤2.5kg >2.5 - ≤5kg >5 - ≤10kg	10mg/50mL 25mg/50mL 50mg/50mL	Glucose 5%w/v NaCl 0.9%w/v Glucose 10%w/v	Sedation: 0-4microgram/kg/min	1microgram/kg/min	0.3 x Wt 0.12 x Wt 0.06 x Wt
Morphine	CNS	≤2.5kg >2.5 - ≤5kg >5 - ≤10kg	2.5mg/50mL 5mg/50mL 10mg/50mL	Glucose 5%w/v NaCl 0.9%w/v Glucose 10%w/v	Neonate: 0-20microgram/kg/hr >1mth old:0-40microgram/kg/hr	20microgram/kg/hr	0.4 x Wt 0.2 x Wt 0.1 x Wt

Frequently used intermittent medications

Doses for quick reference only – please prescribe using the CHI 'CLINIBEE' app or after direct consultation with accepting consultant

Fluid Bolus: Hartmann's Solution 5-10ml/kg
Ca Gluconate 10% w/v: 0.11mmol/kg (max 4.5mmol) as slow IV infusion over 10minutes
Sodium Bicarbonate 8.4%: 1mmol/kg (1ml/kg)
Dextrose 10%: 2ml/kg
Hydrocortisone: 2mg/kg (max up to 100mg)
Phenylephrine Bolus: (5-20mcg/kg – max 500mcg)
Synchronised D/C Shock: 1-2J/kg

In case of cardiac arrest

Adrenaline IV/IO/IM 10mcg/kg (0.1ml/kg 1:10,000)
Amiodarone – (VT/VF after shock 3&5) - 5mg/kg
Atropine – 20mcg/kg (min dose 100mcg, max 600mcg)
Magnesium (if torsade suspected) 50mg/kg – max 2g
D/C shock – VT/VF 4J/kg
AED – Paediatric attenuated if 1-8yrs / Adult >8yr

Useful Checklists & Resources



Stabilisation of
child in Adult ICU



PICU Referral
Tool



Emergency Drug
Calculator



P37 Activation
Guide



Sepsis Guideline



Metabolic Emergency
Guidelines

Time Critical Pre-Departure Checklist

Neonatal Collapse

To be completed by referring team prior to departure
Contact the accepting PICU intensivist via
1800 222 378 for advice during transfer

Airway / Ventilation Considerations

Intubated Child:

Appropriately Sized ETT & NGT well secured

CXR performed & ETT & NGT position reviewed

ETCO₂ & O₂ sats visible on transport monitor targeting ETCO₂ 4.5-6Kpa & Sats 94-98%

Appropriately sized ETT suction catheters available (uncuffed ETT size x2 = Catheter French) i.e. 3.5 cuffed ETT has same internal diameter as a 4.0 uncuffed ETT ∴ (4 x 2) = 8 F suction catheter

Child on NIV/HFNCC:

NGT inserted and attached to bile bag for drainage

Appropriate size intubation equipment available for transfer

HFNCC: Suggest 2L/Kg/min

CPAP: Suggest starting at low PEEP 3/4cmH₂O for tolerance and inc. as required to PEEP of 5-7cmH₂O

Please ensure a blood gas (cap/venous/arterial) is measured once on transport ventilator
Please use the IPATS oxygen calculator to ensure sufficient oxygen for the transfer



Circulation Considerations

It is always recommended that cardiac arrest medications are brought in addition to, and kept separate from, those suggested below

Working Vascular Access x2 (IV/IO)

Continuous ECG monitoring on transport monitor

NIBP set to auto q3-5min if no art line
Please do not delay transfer for art line insertion

Individualised approach to BP management. Discuss targets with PICU/Cardiology before departure

Maintenance & rescue fluid available

Adrenaline infusion prepared and connected to patient even if not immediately required.

If on Adrenaline – call PICU re additional inotrope to prepare– likely Noradrenaline

Push dose pressors: (to correct hypotension)
Choice & dose at discretion of medically responsible consultant.
Caution recommended with use of pure alpha agonists in this context – adrenaline usually first line.

1. Adrenaline **1:100,000**
Add 1ml Adrenaline 1:1,000 to 99ml NS = 10mcg/ml solution (label clearly)
Dose = 0.1ml/kg = 1mcg/kg per dose

2. Ephedrine diluted to conc. of 3mg/ml
Dose for 1-12yr = 500mcg/kg
Dose for >12yr = 3-7.5mg

3. Phenylephrine 100mcg/ml
Dose for >1mo - 12yrs = 5-20mcg/kg
Dose for >12yrs = 100-500mcg/kg

Additional useful drugs to bring: Doses in green box on prev. page
• Calcium gluconate
• Sodium Bicarbonate

Sedation / Neurosurgical Considerations

Tolerance of NIV or procedural sedation:
If required, intermittent fentanyl 0.5-1mcg/kg or ketamine 0.25-0.5mg/kg can be administered. Low dose infusions of same are also generally well tolerated if required

Intubated Children:
Morphine 20mcg/kg/hr + midazolam 2mcg/kg/min suggested starting doses

Suggested bolus CNS medications for transfer

Use & dose at discretion of medically responsible consultant.
Due to reduced cardiac output, please titrate doses and allow additional time for metabolism and eventual effect.

Have push dose pressor of choice available when administering any sedation bolus

Recommended drugs for intubation include:
Ketamine 0.5-1mg/kg (titrated/repeated to effect)
Rocuronium 0.6-1.2mg/kg
+/- Fentanyl 1-2mcg/kg (titrated/repeated to effect)

Avoid propofol/inhaled anaesthetic agents in all ages in this condition

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Related Documents:	

The Irish Paediatric Acute Transport Service (IPATS) in conjunction has produced this clinical guideline with review by the PICU department in CHI and relevant specialists. It has been designed for nurses, doctors and ambulance staff to refer to in the emergency care of critically ill children.

This guideline represents the views of IPATS and was produced after careful consideration of available evidence in conjunction with clinical expertise and experience. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient.

Further reading / Resources

1. Lal N, Varshney T. The collapsed newborn in the emergency department. *BJA Educ.* 2018;18(8):254-258. doi:10.1016/j.bjae.2018.05.004 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7808019/>
2. A practical guide for the management of the collapsed neonate – Part 1 recognition and initial management. <https://resources.wfsahq.org/atotw/a-practical-guide-for-the-management-of-the-collapsed-neonate-part-1-recognition-and-initial-management/>
3. Royal Children’s Hospital Melbourne Clinical Practice Guideline for the Recognition of the seriously unwell neonate and young infant. https://www.rch.org.au/clinicalguide/guideline_index/Recognition_of_the_seriously_unwell_neonate_and_young_infant/
4. Northwest and North Wales Paediatric Transport Service Guide for the management of the collapsed neonate / infant file:///Users/cathygibbons/Downloads/collapsed_neonateinfant_june_2022_-_january_2025.pdf
5. KIDS - NTS Guide to the care of the collapsed infant/neonate <https://kids.bwc.nhs.uk/wp-content/uploads/2021/02/Neonatal-collapse.pdf>
6. North East Children’s Transport and Retrieval Guideline for neonatal collapse. https://www.newcastle-hospitals.nhs.uk/wp-content/uploads/2021/02/NECTAR_Neonatal_collapse_V1.0.pdf
7. Evelina Children’s Hospital & South Thames Retrieval Service Guideline for neonatal collapse: <https://www.evelinalondon.nhs.uk/resources/our-services/hospital/south-thames-retrieval-service/neonatal-collapse-nov-2017.pdf>