

Produced by the Centre for Community Child Health & Ambulatory Paediatrics, Royal Children's Hospital, Melbourne.

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Sponsored by Wyeth - Partners in Infant Nutrition.

Volume 4, Number 3  
Spring 1995

## Irritable Infants

The cry of an infant is designed to stimulate a nurturing response in caregivers; babies come equipped with a cry that is a powerful means of communications. But how do parents learn to interpret a baby's cry? How does the baby learn to be comforted?

Parents may be concerned that excessive crying or frequent night waking is an indication that the baby may be ill or in pain. A cause may be identified that can be remedied, or may just suggest a contributing factor in a well baby.

When serious illness is ruled out the persistent crying of a "difficult" baby may become so hard to bear that it leads to frustration, hopelessness, low self esteem or even abuse.

### What is meant by an irritable baby?

- poor sleepers wake frequently, sleep briefly, or hard to settle
- hard to read, unclear signals of hunger, tiredness, intense crying for everything
- "excessive" crying, lengthy crying periods, even if held, or hours of on/off crying
- clingy, only happy if held by parent especially mother
- unhappy, rarely smiles, always looks unhappy, or parents not "enjoying" him/her
- demanding, unable to wait for attention or extremely upset very quickly
- fussy, stops and starts feeds, grizzly.

## A Concept of Balance

If one views the symptom of distress in the infant as a vehicle for enhancing the parent's understanding of the emotional development of the baby, this may give a base on which to develop advice.

Interpretive and supportive intervention can relieve some of the problems. Practical nursing advice provides a strong preventive and early intervention model of care.



The ability of the mother to interpret her baby's cry and the baby to respond to her efforts, may be kept in balance or harmony by the acknowledgment of factors involved in this fine tuning.

For example, when babies are ill they become harder to console and harder to read. The illness in the baby tips the balance, and unless she can be adequately reassured that the baby is recovering and/or well the mother's anxiety may effect the equilibrium. There may be factors in the mother's life that make it harder for her to be reassured, eg illness in her other children, fear of a specific disease, depression, lack of emotional support.

**BABIES contribute to the cycle of distress by their very nature and behaviour, responding to events and initiating a response from the parent.**

## Management Strategies

### Charting the day

Keeping a record of the day validates the events for the parents. Having it on paper means there is something concrete that may be altered. Patterns may emerge that are the basis for suggested change. Recording the infant's signs of sleepiness or hunger reinforces these, and sets a starting point for a daily routine.

### Develop some pattern & predictability to the baby's day

Part of the baby's sense of security comes from the predictability of the day. The knowledge that events follow each other and that this knowledge helps the baby wait for mother or the comfort he knows will come.

Greenspan's<sup>1</sup> concept of "homeostasis" suggests that newborn babies need to make sense of all the varied stimuli they face and be able to tune in and out as necessary. The pattern also helps parents feel in control and able to plan and predict each day to some extent, not feel they are in a state of chaos.

### Help parents select their consistent response to baby's distress

It is not uncommon for parents to report that they have tried everything to settle the baby and in fact seem to be on a merry-go-round of activity to stop the baby crying or to get him to sleep. Suggest they select the method that feels right for them and be confident that doing this will let the baby go to sleep not to make him/her sleep.

### Understand baby's cues

Many factors may interfere with the transition to homeostasis:- a difficult birth, severe pain, medical symptoms, eg. reflux, colic, diarrhoea. Confident reading of the baby's needs and clear signalling by the baby is necessary for synchrony to be established. The longer the distress goes on the more entrenched the behaviour becomes.

### Exploration of parents' family of origin issues

The adaptation from a couple to a family means developing beliefs about their role as parents based on the type of parenting that each of the couple received. If this history has been difficult, or the current relationship with the family has

unresolved issues, then these feelings may inhibit parents' confident interpretation of the baby's cry or behaviour.

### Referral for further counselling as appropriate

Issues of grief or loss of previous child or pregnancy may affect parents' confidence and discussion of their current relevance may be welcomed.

### Referral to Mother Baby Units

The availability of Residential Mother Baby Units is helpful for those mothers who need support to establish feeding behaviour, sleep patterns, settling techniques.

We need to be confident that we can raise many of these issues knowing that nurses have the skill and support in managing them to maintain the equilibrium for all the family.

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### Reference

Greenspan S. **Psychopathology and Adaptation in Infancy** New York International University Press. 1991

## Gastro-oesophageal Reflux

### Definition

Gastro-oesophageal reflux is the passage of gastric contents from the stomach into the oesophagus.

Possetting, a common phenomenon in young infants, is the passage of gastric contents into the mouth and occurs at least once daily in approximately 80% of infants under the age of three months. It is important to differentiate "trivial" possetting in healthy, normal thriving babies with no significant symptoms and requiring no treatment from gastro-oesophageal reflux which requires treatment.

The common symptoms associated with reflux in infants are discomfort and sometimes pain associated with mild to severe irritability. Anorexia may manifest as difficulty in feeding or reluctance to complete a feed. Vomiting may be associated with haematemesis suggestive of oesophagitis. Aspiration pneumonia or failure to thrive may further complicate matters. In some infants there is the additional complication of apnoeic episodes. Most apnoea is not related to reflux but in some cases reflux has been demonstrated to cause apnoea. Oesophagitis leading to stricture is a rare complication of reflux.

The diagnosis of reflux in most instances is relatively straightforward and generally does not require major investigation. A careful clinical history and normal physical examination will often identify reflux as the cause of the child's problems. If necessary a range of further investigations may be conducted.

### Investigations

#### pH Probe

There have been major advances in the understanding of reflux using pH monitoring. It has been shown that the pH

monitor can provide a very accurate analysis of the degree of acid reflux into the oesophagus. The probe can identify the number and duration of episodes. With this information, a diagnosis can be easily made.

### **Barium studies**

These are of limited value as they may fail to identify reflux at the time of the test or diagnose reflux where there are no significant symptoms. It is useful in excluding anatomical abnormalities that could be contributing to the problem eg. hiatus hernia.

### **Endoscopy**

This is clearly the most useful technique but it is the most invasive because it requires a general anaesthetic. The diagnosis is made through direct visualisation of the oesophageal and gastric mucosa and the obtaining of biopsy specimens.

### **Milk scan**

This is an investigation which is useful in identifying aspiration into the lungs and quantifying gastric emptying. It is not necessary in most children.

### **Ultrasound**

Some studies have found ultrasound to be valuable in measuring gastric emptying in children with reflux. This is a relatively new technique for the diagnosis of reflux.

## **Differential diagnosis**

When a child presents with symptoms suggesting gastro-oesophageal reflux the differential diagnosis includes the following :

### **Urinary tract infections**

It is essential that this is excluded in every child who presents with vomiting and irritability. If there is associated fever other courses of sepsis must also be considered.

### **Gastroenteritis**

This is usually obvious as it has an acute onset with associated diarrhoea.

### **Pyloric stenosis**

This must be excluded in any infant, particularly a male, who presents with projectile vomiting and failure to thrive.

### **Milk allergy**

This is a frequently over diagnosed condition but may present with symptoms of vomiting indistinguishable from reflux.

## **Management**

In many instances, reflux requires no treatment other than adequate explanation to parents of the natural course of the condition. There have been many studies looking at the ideal position for a baby with reflux. Most would agree that the right lateral position with the cot elevated to 45 degrees or the prone posture (now contraindicated because of the association with Sudden Infant Death Syndrome) are useful ways of reducing reflux. There has been an increase in the incidence of reflux since infants have been placed in the supine rather than prone sleeping position. Encouraging parents to carry their baby in their arms or in an appropriate carrying device will improve reflux and reduce crying. Ensuring the baby does not have excessive handling after a feed and trying to be as gentle as possible at those times will also help reduce the likelihood of reflux vomiting.

Thickening the feeds is useful - common ingredients include corn flour, Karicare infant food thickener, rice cereal, Gaviscon and Carobel. The use of thickening feeds has aroused some controversy and some studies have shown that thickening formula did not decrease reflux. If reflux is associated with significant symptoms

such as pain, anorexia, failure to thrive or complications such as aspiration and is confirmed after pH monitoring and endoscopy should be performed. Thereafter the infant should be treated with H<sub>2</sub>-antagonists such as Ranitidine (Zantac) or prokinetic agents such as Cisapride (Prepulsid). These drugs have improved the management of children with reflux but should only be used in children with significant symptoms and who are not responsive to other measures. Recently omeprazole (Losec) has been used in adults with reflux with significant improvement and studies are currently underway in children.

There are many other medications used in the management of reflux including other prokinetic agents such as bethanecol and metoclopramide, but most are best avoided as they may have undesirable side effects.

## **Surgery**

Surgery has always been a last resort in management of reflux. The use of fundoplication (Nissen), has been limited to children with severe reflux associated with complications such as failure to thrive, oesophageal stricture, recurrent aspiration pneumonia or children with other neurological disorders such as cerebral palsy where reflux has not responded to medical treatment. Any patient who has had significant medical treatment without success may need to be considered for surgery.

## **Outcome**

Most children with gastro-oesophageal reflux are treated by simple measures and will undoubtedly improve with time. Explanation and reassurance to parents is an important part of the care of the infant with reflux. Usually the majority of children have stopped significant reflux by the time they are six to twelve months and the more severe cases will generally stop by 18 months.

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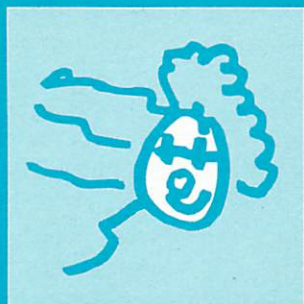
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from  
the   
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## THE DANGER OF FREELY ROCKING CRADLES

S.M. Beal et al. Journal of Paediatrics and Child Health 31 (1) Feb 1995, pp 38-40.

After four infants were found dead in the angle formed by the side bars and the base of tilted, freely rocking cradles in South Australia, this study was organised by the Department of Public and Consumer Affairs to assist the coroner in his investigations. The study sought to assess the maximum possible angle of tilt to protect an infant's airway and the security of locking devices, in the absence of an Australian standard.

Using video recording, eleven infants were filmed at varying degrees of tilt in six commercially available cradles. The locking pins in five of the cradles were not secure, the tilt varied between 6° and 16°, and one cradle already owned by a family tilted to 21°. Arms were caught between the bars and the baby's body when infants rolled to the side of the cradles, and few babies were able to get a clear airway in this position. When babies were lying prone on flat surfaces, they were able to turn their heads from side to side.

The authors recommend that "locking devices on rocking cradles be made to bolt into place, that no infant be left unattended in an unlocked freely rocking cradle, and a warning be placed on the cradle stating this...that cradles be limited to 5° tilt...[which is] sufficient to allow comfortable rocking of the infant".

## ON THE SHELF NEW BOOKS

Helen Rowan, Manager  
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### "FOR CRYING OUT LOUD"

#### Understanding and Helping Crying Babies

**Author:** Margaret Hope 1992 (reprint 1994) pp 48.

Price \$8.50 plus \$1 postage and handling.

This small book is not new but is still a much needed resource for both parents and health professionals. "For Crying Out Loud" is written by Margaret Hope, an occupational therapist with the Prince of Wales Hospital, Sydney. Margaret is widely recognised for her expertise in helping parents and children to understand and manage difficult babies and children.

This book offers parents a better understanding of their crying child. The author encourages parents to follow their nurturing instincts and to use existing strategies already in practice but modified to "do what feels right" for them.

At first glance the presentation of the content does not look easy for a tired and stressed parent but chapter headings are encouraging, for example, "Management - Restoring parents faith in themselves - Strengths and Choices". The brief repetitive messages throughout the book are also reassuring and acknowledge parent as feelings of confusion, pressure and guilt. The frequent reminders to

parents to comfort and calm their baby are a positive way to overcome these feelings of inadequacy and help to make this book a popular choice for parents.

Available from The Child Health Information Centre, a specialist bookshop, information and referral centre for health professionals, parents, teachers, adolescents, and students.

A complete booklist is available for mail orders:

Phone (03) 9345 6429,  
9.30 - 4.00 weekdays.