Neonatal Apnea and Bradycardia

Reviewed and Accepted by Corporate Medical Affairs Committee (CMAC)

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Purpose: To provide guidelines to determine the optimal course of treatment and subsequent case management of the neonate with neonatal apnea.

Target Client Population: Convalescent preterm and term neonates with the following diagnosis(es): Apnea: with co-existing bradycardia, and/or significant hypoxemic desaturations.

Background

For decades investigators have tried to understand the complex developmental neuropathology involved in apnea of prematurity (AOP) in an effort to interrupt or treat apnea and remove its impact on Apparent Life Threatening Events (ALTE’s), apnea spell sequelae, and death from Sudden Infant Death Syndrome (SIDS).

A clinical report on AOP from the American Academy of Pediatrics indicates an apneic episode is typically defined as a pause in breathing of ≥ 20 seconds or a shorter interruption associated with bradycardia (<100 beats per minute), pallor or cyanosis. (Eichenwald, 2016)

The same report notes cardiac alarms set at a lower heart rate alarm setting are acceptable in convalescing infants greater than 33-34 weeks corrected gestational age. In these infants, pathologic apnea is commonly defined as lasting for 20 seconds duration or longer or for less than 20 seconds when accompanied by a significant decrease in heart rate <80 beats per minute or oxygen saturation <85% (excluding transient oxygen desaturation <85% without need for supplemental oxygen). (Finer, 2006)

In stable term infants, heart rates as low as 70 beats per minute while sleeping are acceptable. (Benitz, 2015)

Apnea of infancy, as opposed to AOP, refers to infants > 37 weeks’ gestation at the onset of apnea and is more likely to be associated with an underlying etiology. (NIH, 1987)

Recurrent apnea events are a frequent manifestation of general problems in preterm infants often resulting in loss of effective breathing that can sometimes lead to severe hypoxemia and bradycardia requiring resuscitation.
The clinical goal is establishment of regular breathing patterns in infants to facilitate a safe discharge from the NICU and, in select patients, outpatient follow up until they “outgrow” their respiratory control immaturity.

Supportive as well as pharmacological treatments are incorporated into clinical practice to diminish the frequency and severity of central apneas. The challenge with neonates is determining when to safely remove treatment medically and/or monitoring electronically and let the infant mature and self-regulate his or her own breathing.

### Treatment Criteria

**Clinical evidence supports the following:**

#### Diagnostic(s)

- Apnea and bradycardia experienced during feeding is not directly related to AOP. Events are not more prevalent post-feeding. (Slocum, 2009)

- Feed-related events that do not cease following interruption of the feeding should prompt for immediate caregiver feeding education and training.

- Gastroesophageal Reflux (GER) is rarely associated with apnea. Antireflux medications (e.g., antacids, prokinetic agents, proton-pump inhibitors) are not recommended in the neonate due to ineffectiveness and potential treatment complications. (Tipnis, 2009; Wheatley, 2009; Eichenwald, 2016; Ho, 2015)

- Apnea and/or bradycardia induced by care interventions (e.g., eye examination, suctioning, placement of a gavage tube) are typically not associated with an underlying pathology.

- Term infants should have an appropriate evaluation for the etiology of apnea and hospital stay should be based on the underlying diagnosis and related co-morbidities.

- Pneumocardiograms (PCGs) are not recommended in the management of apnea because they have a high false-positive rate, cannot predict with accuracy the occurrence of severe apnea or death, and are not beneficial in identifying which patients should be discharged with a home monitor. (AAP, 2008)

#### Medication Therapy

- Methylxanthines (caffeine, aminophylline and theophylline) help to reduce the frequency of events in infants with central apnea and are appropriate.
- Caffeine is the only FDA approved treatment for AOP and is the preferred drug of choice for this indication particularly due to its long half-life, wide therapeutic index and lack of need to monitor drug level. Theophylline is not recommended due to its side effects including the increased risk of seizures, tachycardia and feeding intolerance.

- It is recommended to discontinue caffeine once the infant is apnea free for 5-7 days off positive airway pressure (defined by high-flow nasal cannula or CPAP) or by 33-34 weeks, whichever comes sooner. (Eichenwald, 2016) Failure to stop caffeine in a timely manner can lead to an unnecessary delay in discharge.

- An observation period of 5 days for infants born > 30 weeks gestation and 7 days for infants born ≤ 30 weeks after discontinuing caffeine is a reasonable time frame for demonstrating cardio-respiratory stability before a safe hospital discharge.

### Home Monitoring

- Home apnea monitoring might be considered for infants discharged home on caffeine.

- An association between AOP and an increased risk for SIDS is not supported in the medical literature. (Eichenwald, 2016) Due to lack of medical evidence, home monitoring to prevent SIDS is not recommended.

- Home respiratory monitoring may be warranted to recognize events in premature infants who are at high risk of recurrent episodes of apnea, bradycardia, and hypoxemia.

- Home apnea monitors would be appropriate for neonates who have experienced an ALTE and who are technology-dependent (ventilator, tracheostomy with collar, gastrostomy, etc.), have unstable airways, have rare medical conditions affecting regulation of breathing, or have symptomatic chronic lung disease.

- CPR and home monitoring equipment training for parent(s)/caregivers(s) are recommended prior to discharge.

- Any parent/caregiver rooming-in to familiarize themselves with the infant’s habits on the monitor should occur while the infant requires continued hospitalization prior to meeting discharge criteria.

- The use of home cardiorespiratory monitoring up until 43 weeks post menstrual age (PMA) may be considered for infants who continue to have...
Apnea Countdown/Discharge

- An apnea/bradycardia “countdown” of 5 days for a preterm infant is a reasonable period to demonstrate cardio-respiratory stability before a safe hospital discharge. However, for infants born at $\leq 30$ weeks’ gestation a 7-day countdown may be appropriate. There may be select infants born at less than 26 weeks’ gestation that warrant a longer observation period prior to discharge based on their individual frequency and severity of events. (Eichenwald, 2016)

- In convalescing preterm infants, brief isolated self-limited bradycardia occurrences and feed-related events that cease with interruption of the feeding are not indications to delay discharge. (Eichenwald, 2016) Extended stay for a brief observation period may be warranted based on the degree and duration of the bradycardia event.

- For infants who have feeding-related events that do not cease with interruption of the feeding, consideration should be given to providing the caregiver feeding education and training with appropriate discharge follow-up. “Full” countdown periods are not indicated.

- Brief self-limited oxygen desaturation events are not an indication to delay discharge. Extended stay for a brief observation period may be warranted based on the degree and duration of the desaturation event.

- Routine screening of infants with PCGs is not appropriate and its use is not an applicable reason to delay discharge from the hospital. (AAP, 2008; Ho, 2015)

- An apnea/bradycardia countdown of up to 3 days following the last event for a term infant is appropriate.

- Since apnea, bradycardia and oxygen desaturation can persist in maturing preterm infants, repeat countdowns, in general, should be reserved for infants with events needing significant intervention. (Ramanathan, 2001)

- If an infant fails two apnea countdowns, consideration should be given to discharge on a home monitor, initiation or restart of caffeine, or a search for other etiologies.

Clinical Evidence

- A clinical report from the American Academy of Pediatrics authored by Eichenwald et al (2016) reviewed the evidence on the definition, epidemiology and treatment of AOP. Based on an observational study by
Henderson-Smart it was noted that the proportion of infants with apnea decreases significantly with increasing gestational age, particularly beyond 30 weeks’ gestation. A significant variation in apnea monitoring practices among NICUs was observed. Implementation of policies and procedures for documenting and monitoring cardiorespiratory events would promote consistency in discharge timing. Discharge readiness would include an event-free period of time which may require individualization based on the infant’s gestational age at birth and characteristics of the recorded events.

- As part of the “Choosing Wisely” campaign Ho et al (2015) identified five tests and procedures in newborn medicine that contributed to health care waste. Two of these items were focused on preterm infants with apnea. The authors indicated the routine use of pneumograms for evaluation of ongoing and/or prolonged apneic events prior to discharge should be avoided because routine testing has not demonstrated a reduction in acute life-threatening events or mortality. It was also noted that the routine use of GER medications should be avoided. Not only is there a paucity of evidence supporting their efficacy in treating apnea and desaturation, several clinical studies have demonstrated adverse physiological effects in infants.

**SIDS**

- In 2004, Kiechl-Kohlendorfer, et al performed a prospective study of 164 infants to investigate whether there was an association between SIDS and ALTE. The authors found several substantial differences in SIDS and ALTE epidemiology including age at event, with ALTE manifesting 10 weeks earlier on average. In addition, smoking in pregnancy was the only prominent SIDS risk condition that emerged as a significant risk predictor of overall ALTE. Of note, none of the ALTE infants experienced SIDS later in life. The authors concluded that although there are some similarities in the clinical presentation and epidemiology between SIDS and ALTE, they should not be considered different manifestations of the same disease.

- In an article by Zhoa, et al (2011), the authors stated that the risk factors for SIDS in premature infants were strongly associated with maternal age, tobacco use, meteorologic factors and genetics but not AOP.

**Diagnostics**

- In an article by Slocum, et al (2009), the authors conducted a retrospective review of premature infants with a gestational age of 23 to 37 weeks at birth and a post-conceptional age of 34 to 48 weeks to determine if GER and cardiorespiratory events increase after feeding. The authors concluded the common clinical impression that apnea, bradycardia and desaturations are more prevalent after feeding is not supported.
• A 2010 article by Poets indicated that hypoxemia during feeding was most likely related to an immature coordination between sucking, swallowing and breathing and potentially to an immature laryngeal chemoreflex. Hypoxemia after feeding may be caused by diaphragmatic figure, gastro-esophageal reflux only rarely played a role.

• A 2011 article by Mathew on the pathogenesis and management of AOP stated while both GER and apnea are common in very low birth weight infants, there is no compelling evidence supporting a causal relationship between the two. He noted that there were well designed studies that have shown no temporal relationship between GER and apnea.

• In 2011, the American Academy of Pediatrics reaffirmed a 2008 policy statement on Hospital Discharge of the High Risk Neonate. This policy statement indicated that formal laboratory analyses of breathing patterns (i.e., pneumograms) were of no value in predicting SIDS and were not helpful in identifying patients who should be discharged with home monitors.

• In 2013, Mittal, et al, performed a prospective observational study of 300 infants diagnosed with ALTE to determine if a positive result on pneumography, diagnosis of gastroesophageal reflux disease (GERD), or non-treatment of those diagnosed with GERD with antireflux medications predicted an increased recurrence risk of ALTE over the first 4 weeks of follow-up. The study found that of the 228 admitted patients, 110 had pneumography. Of these, 41 were positive for apnea, GER or both. Six of these 41 infants had a recurrent ALTE during the 4 week follow-up as compared with 8 of 69 infants with normal pneumography. The authors concluded that an abnormal result on pneumography for apnea/reflux did not predict increase in recurrence rate of ALTE during the subsequent 4 weeks and that a negative pH probe study does not affect the decision to diagnose or treat GERD where clinically indicated thus questioning the justification for doing pneumography or pH probe studies in infants with ALTE.

• A review by Finer et al (2006) discussed apnea of prematurity and defined “clinically significant apnea” as outlined in the literature. The authors indicated that a breathing pause lasting longer than 20 seconds or a breathing pause lasting longer than 10 seconds that is associated with bradycardia or oxygen desaturation should be considered as a clinically significant apnea in an infant.

• The panel for the Consensus Development Conference on Infantile Apnea and Home Monitoring (NIH 1987) defined apnea of prematurity as periodic breathing with pathologic apnea in a premature infant that usually ceases by 37 weeks gestation (menstrual dating). Apnea of infancy was a term that pertained to infants who were > 37 weeks gestational age when the pathologic
apnea commenced.

- Benitz and the Committee on Fetus and Newborn (2015), developed a policy statement reviewing issues related to the length of initial hospitalization and readmissions in healthy term infants. Recommendations on the minimum discharge criteria for a term infant included stable vital signs for 12 hours preceding discharge. This document noted that a heart rate as low as 70 beats per minute is acceptable for a sleeping infant who is not demonstrating any signs or symptoms of circulatory compromise.

**Medication Therapy**

- In 2006, Schmidt, et al, randomly assigned infants with birth weights of 500 to 1250 g during the first 10 days of life to receive either caffeine or placebo, until drug therapy for apnea of prematurity was no longer needed. Of the infants who were assigned to caffeine and who remained alive at a postmenstrual age of 36 weeks, 36 percent received supplemental oxygen, as did 47 percent assigned to placebo. Positive airway pressure was discontinued one week earlier in the infants assigned to caffeine (median postmenstrual age, 31.0 weeks) than in the infants in the placebo group (median postmenstrual age, 32.0 weeks. The authors concluded that Caffeine therapy for apnea of prematurity reduced the rate of bronchopulmonary dysplasia in infants with very low birth weight.

- In 2007, Schmit, et al, randomly assigned infants with birth weights of 500 to 1250 g during the first 10 days of life to receive either caffeine or placebo, until drug therapy for apnea of prematurity was no longer needed. Treatment with caffeine as compared with placebo reduced the incidence of cerebral palsy (4.4% vs. 7.3%) and of cognitive delay (33.8% vs. 38.3%). The rates of death, deafness, and blindness and the mean percentiles for height, weight and head circumference at follow-up did not differ significantly between the two groups. The authors concluded that caffeine therapy for apnea of prematurity improved the rate of survival without neurodevelopmental disability at 18 to 21 months in infants with very low birth weight.

- In 2009, Mueni, et al, reviewed the literature regarding current management strategies for infant apnea. The authors concluded that the two most widely used methylxanthines, caffeine and theophylline, were typically prescribed in preterm infants till a gestational age of 34 to 35 weeks. However, caffeine was found to be safer and easier to give and had better therapeutic properties. Caffeine was therefore recommended for the treatment of apnea.

- In 2010, Henderson-Smart, et al, reviewed the results of six trials that reported on the effects of methylxanthine therapy on apnea. In these studies, caffeine therapy led to a reduction in apnea and use of IPPV in the first two to seven days. The authors concluded that caffeine was effective in reducing the
number of apneic attacks and the use of mechanical ventilation in the two to seven days after starting treatment. Caffeine was also associated with better longer term outcomes. In view of its lower toxicity, caffeine was the preferred drug for the treatment of apnea.

- In an article by Picone, et al (2012), the authors concluded that the duration of (caffeine) therapy for treating AOP had not been clearly established. There were no indications on whether therapy should be continued until the end of gestation or whether it should be discontinued at an earlier stage, once an apnea regression of at least one week has been observed and with a possibility of recommencing treatment in the event of recurrence. The authors additionally stated that given that AOP usually spontaneously resolves around 36-40 weeks of gestation, the treatment should be extended to this age.

- In 2013, Francart, et al, reviewed the results of a retrospective trial and concluded that (caffeine) therapy was typically continued until 32 to 34 weeks of age and it was common practice at North Carolina Children’s Hospital to allow the patient to outgrow their maintenance dose.

- In 2014, Schoen, et al, reviewed the literature on neonatal methylxanthine therapy and found that methylxanthine therapies, including caffeine and theophylline are a mainstay in the treatment and prevention of AOP, although little is known about the long-term safety and efficacy of these medications. They noted that caffeine was associated with fewer adverse effects and had a wider therapeutic window when compared with theophylline. Caffeine was shown to improve acute neonatal outcomes when used promptly in larger doses.

- Marcus et al (2014) evaluated the long-term effects of caffeine therapy utilized for apnea of prematurity. The authors sought to examine whether therapeutic neonatal caffeine administration resulted in long-term adverse effects on sleep architecture and ventilatory control. This prospective follow-up study of the Caffeine for Apnea of Prematurity (CAP) trial included 201 subjects aged 5-12 years who had been randomized to receive caffeine versus placebo as preterm neonates. After review of actigraphy, polysomnography and parental sleep questionnaire results no long-term adverse effects on objective or subjective sleep measures at school age were identified. No differences in sleep architecture were apparent between the children who had received caffeine therapy and the placebo group.

- An additional follow-up study of the Caffeine for Apnea of Prematurity (CAP) trial was performed by Doyle et al (2014). The authors evaluated whether caffeine therapy affected rates of developmental coordination disorder (DCD) in prior preterm neonates. After 1,433 five year old children were examined for clinical signs of cerebral palsy and assessed using Full-
In 2001, Ramanathan, et al, performed a longitudinal cohort study of 1079 infants to determine if preterm infants, siblings of infants who died of SIDS and infants who had experienced an idiopathic, ALTE had a greater risk of cardiorespiratory events than healthy term infants. The authors found that the likelihood of experiencing at least one extreme event decreased as postconceptional age (PCA) increased until about 43 weeks PCA, after which all groups had similarly low rates of having at least one extreme event.

In 2009, Silvestri performed a review of existing data in order to determine when it was appropriate to discontinue monitoring at hospital discharge versus when it was appropriate to prescribe monitoring in the home. He noted that when maturing cardiorespiratory patterns and resolving apnea of prematurity had contributed to an apparent life threatening event (ALTE), monitoring through age 43 weeks documenting resolution of apnea and bradycardia was usually insufficient.

Darnall, et al (1997), performed a retrospective review of 91 infants to determine the length of time one should wait after the cessation of apnea before sending an infant home without a monitor. The authors concluded that otherwise healthy preterm infants continued to have apneas separated by as
many as 8 days before the last apnea before discharge.

- Eichenwald, et al (2001), studied premature infants delivered at 30 to 34 6/7 weeks gestational age (GA), who were free of significant medical or surgical complications and compared postmenstrual age (PMA) at discharge to assess the impact on hospital stay of the recognition and recording of physiologic maturity and the required margin of safety. The authors concluded that NICUs vary widely in length of hospital stay for healthy premature infants. They speculated that this variation resulted in part from differences in monitoring for and documentation of apnea of prematurity and feeding behavior.

- Lorch, et al (2011) performed a retrospective cohort study of infants born at 34 weeks gestational age or earlier. This study found that there was a 95% success rate reached with a 7 day apnea or bradycardia free interval. Infants with a gestational age of 30 weeks or less had a 5% to 15% lower success rate than infants with a gestational age more than 30 weeks. The authors concluded that the risk of recurrence for apnea or bradycardia differed depending on the gestational age of the infant and the postmenstrual age of the last apnea or bradycardia event.

- Eichenwald, et al (2011) performed a multicenter prospective cohort study of moderately preterm infants to determine whether the variability in length of stay would be affected by the rate of documented apnea. The authors concluded that NICU’s vary in the proportion of moderately preterm infants diagnosed with apnea, which significantly affects length of stay.

References


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