cpqcc
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quality care collaborative

TIP SHEET

Primary Care for Preterm Infants & Children

Recommendations and guidelines for providing care for preterm infants and children come from a variety of national organizations including the American Academy of Pediatrics (AAP), the Centers for Disease Control (CDC), and the Advisory Committee on Immunization Practices (ACIP). The Primary Care for Preterm Infants and Children Tip Sheet summarizes key recommendations from the associated toolkit to support primary care pediatric providers as they care for preterm infants and children.

NUTRITION: Monitor growth carefully using adjusted age on appropriate growth charts. Always support breastfeeding. Supplement with post-discharge formulas when indicated to maintain growth trajectory. Do not overfeed.	
Monitoring growth	Use corrected age (adjusted for prematurity) until at least 2 years of age. Use corrected age (adjusted for prematurity) until at least 2 years of age. • WHO growth chart until 2 years • CDC growth chart for children 2-20 years
Breastfeeding	Always promote breastfeeding.
Post-discharge formulas	Length of use of post-discharge formula (usually EnfaCare® or NeoSure®) is controversial without standard recommendations and should not replace breast milk in an adequately growing infant. • BW >1800 grams – may not be necessary • BW 1501-1800 grams – up to 3 months • BW 1001-1500 grams - up to 6 months • BW 751-1000 grams - up to 9 months • BW <750 grams - up to 12 months. Caloric density and frequency of post-discharge formula will depend on growth history in the NICU and other medical issues. Monitor growth carefully and do not overfeed infants who are gaining weight very rapidly.
Reflux	Reflux is almost universal in preterm infants, and in most cases treatment with positioning or pharmacological agents is not indicated and may cause harm.
Vitamin supplementation	**VITAMIN D:** Almost all infants need Vitamin D supplementation. • 400 IU per day recommended <1 year old • Formulas in US contain at least 400 IU per liter • Supplement all breastfeeding infants taking less than 1 liter of formula per day **IRON:** Almost all preterm infants should receive iron supplementation. They are iron deficient unless they received blood transfusions. • Maintenance dose 2-3 mg/kg/day for 6 to 12 months (until dietary intake is sufficient) • Treatment dose 4-6 mg/kg/day if anemic

IMMUNIZATIONS: Follow standard recommendations by chronological age except for special recommendations for Hepatitis B Vaccine and Rotavirus Vaccine.	
Hepatitis B vaccine	Hepatitis B vaccine is the only routine childhood vaccine that has been shown to produce insufficient immunogenicity in preterm and low birth weight babies. A dose received by an infant <2000 grams AND <1 month of age does not count towards the primary series.
Rotavirus vaccine	Infants generally do not receive rotavirus vaccine in the NICU (though a few NICUs administer it at discharge). The first dose of Rotavirus Vaccine must be administered by age 14 weeks 6 days. If not previously given, consider administering at the first outpatient visit for infants 6 weeks to 14 weeks 6 days.
RSV Immunization	***Do not miss the opportunity to protect vulnerable children from Respiratory Syncytial Virus infections.*** Give nirsevimab for the following patients: • Infants < 8 months during RSV season if not given at birth hospitalization or if birthing person received RSV vaccine at least 14 days before birth • Infants 8-19 months at start of RSV season with chronic lung disease of prematurity, immunocompromised, cystic fibrosis with severe lung disease or weight-for-length < 10%ile, and American Indian and Alaska Native children • Complete recommendations: cdc.gov/rsv and aap.org/en/patient-care/respiratory-syncytial-virus-rsv-prevention/ If nirsevimab is unavailable, consider palizivumab for the following patients: • Infants < 12 months at start of RSV season if < 29 weeks GA at birth or < 32 week GA and O2 requirement for at least 28 days • Infants < 12 months with hemodynamically significant heart disease (may consult with cardiologist) or with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions • Children < 24 months at the start of RSV season with chronic lung disease on medical therapy (oxygen, chronic corticosteroid, or diuretic therapy) within 6 months of start of RSV season • Complete recommendations: https://pediatrics.aappublications.org/content/134/2/415.full

SCREENING: Preterm infants and children need more frequent hearing and ophthalmologic screenings and careful monitoring for neurodevelopmental and psychosocial issues.	
Developmental Screening	• Surveillance at every WCC visit • Evidence based tools at 9, 18, 30 months • Autism spectrum disorder screening tool at 18 months and 2 years
Hearing screening	• ABR screening (such as ALGO) prior to discharge • If inpatient screen was not passed, repeat outpatient screening as quickly as possible and by one month of age. Identify any hearing deficit using ABR by 3 months of age. Begin intervention by 6 months of age • If inpatient screen was normal, repeat hearing screening by 9 months. Screen earlier for high-risk conditions, such as history of CMV infection, meningitis, and ECMO • Audiology referral advised at any time for concerns or language delays
Ophthalmologic screening	• Monitor for retinopathy of prematurity (ROP) until mature retinae for birthweight ≤1500 g or GA ≤30 weeks or selected infants either 1500-2000 g or GA >30 weeks • For all, follow up ophthalmologic exam 4-6 months after NICU discharge and yearly
Psychosocial screening	• At every WCC and other visits as feasible and indicated by risk status