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**USING OF DEXMEDETOMIDINE  
IN TERM NEONATES  
WITH HYPOXIC-ISCHEMIC  
ENCEPHALOPATHY**

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КЗ «Дніпропетровська обласна дитяча клінічна лікарня» ДОР»

відділення анестезіології та інтенсивної терапії для новонароджених

(головн. лікар – Н.А. Дементьєва)

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**Цитування:** Медичні перспективи. 2019. Т. 24, № 2. С. 24-33**Cited:** Medicni perspektivi. 2019;24(2):24-33**Key words:** hypoxia, ischemia, encephalopathy, dexmedetomidine, neonates, mechanical ventilation**Ключові слова:** гіпоксія, ішемія, енцефалопатія, дексмедетомідин, новонароджені, штучна вентиляція легень**Ключевые слова:** гипоксия, ишемия, энцефалопатия, дексмедетомидин, новорожденные, искусственная вентиляция легких

**Abstract.** Using of dexmedetomidine in term neonates with hypoxic-ischemic encephalopathy. Surkov D. The negative impacts of standard pharmacologic sedative agents suggest that alternative agents should be investigated. Dexmedetomidine could be the new option for sedation in newborns with hypoxic-ischemic encephalopathy requiring mechanical ventilation. The aim – to determine the impact of dexmedetomidine and other sedatives on the cerebral blood flow and outcomes of hypoxic-ischemic encephalopathy in term neonates. Data of 205 term infants with hypoxic-ischemic encephalopathy by Sarnat scale stage II-III were collected during  $\leq 72$  hours of life. The infants were divided using a simple open randomization by pharmacological sedative agents during mechanical ventilation into dexmedetomidine group ( $n=46$ ) and the control group ( $n=159$ ), which included morphine, sodium oxybutyrate, and diazepam in standard recommended doses. A comparative analysis of the effect of dexmedetomidine and other drugs on cerebral perfusion and outcomes of hypoxic-ischemic encephalopathy was performed. A significant difference between groups in days of trachea extubation ( $p=0.022$ ) was found; the chance for babies to be extubated before the 7th day of treatment was significantly higher in the dexmedetomidine group 68% versus 33% in the control group ( $p=0.018$ ) with HR 0.48 (95% CI 0.27-0.86,  $p=0.011$ ). Also, the NIRS index  $rScO_2$  differed significantly between the studied and control groups on the 1<sup>st</sup> day of treatment (65% versus 79%,  $p=0.012$ ) and on the 2<sup>nd</sup> day of treatment (74% versus 81%,  $p=0.035$ ). Mean arterial pressure was higher in the dexmedetomidine group compared to the control group – (58 [51-65] mm Hg versus 53 [46-60] mm Hg,  $p<0.001$ ), with a lower dose of dobutamine (EV -1.87, 95% CI from -3.25 to -0.48,  $p=0.009$ ). In the dexmedetomidine group, the rate of seizures was significantly lower on the 1<sup>st</sup> day of observation (4.3% versus 48.3%,  $p<0.001$ ); the incidence of unfavorable outcome such as cerebral leukomalacia was also 7 times lower in the dexmedetomidine group compared to the control group (2.2% versus 15.1%,  $p=0.018$ ). Dexmedetomidine is a safe sedative agent with a stable hemodynamic profile, without adverse influence on cerebral perfusion and possible neuroprotective effects in term infants with HIE, as addition to standard therapeutic hypothermia.

**Реферат.** Застосування дексмедетомідину в доношених новонароджених з гіпоксично-ішемічною енцефалопатією. Сурков Д.М. Негативний вплив стандартних фармакологічних седативних препаратів свідчить про необхідність пошуку альтернативних медикаментозних засобів. Дексмедетомідин може бути новим варіантом для седації в новонароджених з гіпоксично-ішемічною енцефалопатією, які потребують штучної вентиляції легень. Мета – порівняти вплив дексмедетомідину та інших седативних засобів на стан мозкового кровотоку та результати лікування гіпоксично-ішемічної енцефалопатії в доношених новонароджених. Досліджено 205 доношених новонароджених з гіпоксично-ішемічною енцефалопатією за Sarnat II-III ст. у терміні  $\leq 72$  годин після пологів. Немовлята були розподілені методом простої відкритої рандомізації за фармакологічним препаратом для медикаментозної седації під час проведення штучної вентиляції легень на групу дослідження ( $n=46$ ) із застосуванням дексмедетомідину та групу контролю ( $n=159$ ), в яку увійшли морфін у монотерапії або в комбінації з натрію оксибутиратом чи діазепамом у стандартних рекомендованих дозах. Проведений порівняльний аналіз впливу дексмедетомідину та інших лікарських засобів на стан церебральної перфузії та на результати лікування гіпоксично-ішемічної енцефалопатії. Отримана достовірна відмінність поміж групами щодо строків екстубації трахеї в немовлят

( $p=0,022$ ), вірогідність для дитини бути екстубованою до 7 доби лікування була значно вищою в групі дексметомідину – 68% проти 33% у групі контролю ( $p=0,018$ ) з коефіцієнтом ризику HR 0,48 (95% CI 0,27-0,86;  $p=0,011$ ). Також достовірно відрізнялись поміж досліджуваною та контрольною групами показники церебральної оксиметрії в 1-у (65% проти 79%,  $p=0,012$ ) та 2-у добу лікування (74% проти 81%,  $p=0,035$ ). Значення середнього артеріального тиску були вище в групі дексметомідину порівняно з контролем (58 [51-65] мм рт.ст. проти 53 [46-60] мм рт.ст.,  $p<0,001$ ), при меншій дозі добутаміну (EV -1,87; 95% CI від -3,25 до -0,48;  $p=0,009$ ). У групі дексметомідину на 1-у добу спостереження була істотно менша частота судом (4,3% проти 48,3%,  $p<0,001$ ); частота розвитку небажаного результату лікування у вигляді церебральної лейкомаляції також була в 7 разів нижче в групі дексметомідину порівняно з контрольною групою (2,2% проти 15,1%,  $p=0,018$ ). Дексметомідин є засобом для седації із задовільним профілем безпеки, стабільною гемодинамікою, відсутністю негативного впливу на церебральну перфузію та можливою нейропротективною дією в доношених новонароджених з ГІЕ як доповнення до лікувальної гіпотермії.

Hypoxic-ischemic encephalopathy (HIE), despite significant advances in diagnostics and understanding of the fetal and neonatal pathologies, remains one of the most frequent reasons for cerebral palsy and other types of severe neurodevelopmental impairment in children [6, 41]. In the United States and most technologically developed countries of the world the frequency of HIE according to different authors varies from 1.5-4 to 1-8 cases per 1,000 childbirths [8, 18, 19]. HIE morbidity is much higher in resource-limited settings and can reach as many as 26 cases per 1,000 newborns [1, 29]. In total it is associated with at least a quarter of all newborn deaths, however in the low-resources countries it could share amounts to 96% of all 1.15 million cases of HIE revealed in the world [15, 24, 31].

Sedation of neonates with HIE requiring mechanical ventilation is one of the debatable issues in neonatal intensive care. Conventionally, opiates or benzodiazepines are the pharmacologic agents most often used for treatment [23]. Questions regarding the efficacy, safety, and neurodevelopmental impact of these therapies remain. They possess certain advantages and disadvantages over each other, consequently, no ideal sedative agent for neonates has been established so far [13, 22]. Such pharmacological agent should provide mild to moderate depth of sedation with retaining a spontaneous breathing pattern, without serious negative effect on the systematic hemodynamics as well as on blood, coagulation, metabolism, liver function, kidneys, etc. It may cause neither long-term addiction in case of withdrawal nor neurodevelopmental retardation. The negative impacts of standard pharmacologic agents suggest that alternative agents should be investigated. So, recently great attention has been paid to such sedative drugs as clonidine [37] and its derivate dexmedetomidine [21, 32].

Dexmedetomidine is an  $\alpha_2$ -adrenoceptor agonist, clonidine derivate, with sedative, anxiolytic, sympatholytic, and analgesic-sparing effects, and minimal depression of respiratory function. Compared with clonidine, an  $\alpha_2$ -agonist that has been used for

several decades, dexmedetomidine has a greater selectivity for  $\alpha_2$ -receptors. As activation of central  $\alpha_1$ -adrenoceptors reduces sedative effects of  $\alpha_2$ -receptors, dexmedetomidine is a more potent sedative than clonidine. Dexmedetomidine exerts its hypnotic action through activation of central pre- and postsynaptic  $\alpha_2$ -receptors in the locus coeruleus, thereby inducing a state of unconsciousness similar to natural sleep, with the unique aspect that patients remain at mild sedation level. This aspect, combined with the minimal influence on respiration, makes dexmedetomidine an interesting alternative sedative in long-term ventilated patients. The impact on the cardiovascular system depends on the dose; in case of lower rates of infusion the central action prevails, which leads to the decrease in heart rate and arterial pressure. At higher doses peripheral vessel-constricting effects prevail, it leads to the increase in the systemic vessel resistance and arterial pressure whilst the bradycardic effect becomes manifested [7].

The evidences of the efficacy and safety of dexmedetomidine using in adults have been obtained in some multi-center controlled studies [2]. The data on newborns (28-44 weeks of gestation) have been limited so far and administration of dexmedetomidine is considered mainly in low doses ( $\leq 0.5$  mcg/kg/h) [10, 40]. No significant pharmacokinetic difference depending on the gender and age of patients was revealed. Newborn babies can be more sensitive to bradycardic effects of dexmedetomidine at therapeutic hypothermia and in clinical conditions when the heart rate depends on the cardiac output [17, 44]. However according to the data of the clinical observations, the episodes of bradycardia were registered in neonates more seldom compared to the pediatric population, but the children required higher doses of dexmedetomidine, therefore bradycardic side effect is dose-dependent [12].

To date there are no age-based contraindications to the administration of dexmedetomidine, and the experience of its using shows dexmedetomidine to be a safe and effective sedation agent for both term

and preterm neonates, it is well tolerated and possesses no severe side effects [3].

Moreover in recent years, additional experimental information on relatively neuro-protective features of dexmedetomidine has been accumulated in researches on animals, at the expense of apoptosis slowing down, of neurons including [25, 26, 27, 30, 43].

Purpose – to determine the impact of dexmedetomidine and other sedatives on the cerebral blood flow and outcomes of hypoxic-ischemic encephalopathy in term neonates.

#### MATERIALS AND METHODS OF RESEARCH

Single-center, prospective, randomized controlled study was performed in 205 full-term infants with HIE treated in neonatal intensive care unit (NICU) level III of Dnipro Regional Children's Hospital (Ukraine) in the period of 2012-2017.

Inclusion criteria: gestational age – 37 to 42 weeks, term infants with the present signs and symptoms of moderate to severe HIE by Sarnat score (in Hill A., Volpe J.J. modification, 1994) at admission during the first 72 hours of life.

Exclusion criteria: gestational age less than 37 weeks, infants aged over 72 hours of life, birth trauma, congenital malformations, early onset of neonatal sepsis.

All the babies were treated by mild therapeutic hypothermia 33-35 °C for 72 hours, assisted positive-pressure ventilation under routine control of acid-base balance, monitoring of SpO<sub>2</sub> and etCO<sub>2</sub>, control of systemic hemodynamics (heart rate, mean blood pressure (MBP), cardiac output). Cerebral hemodynamic was evaluated by non-invasive method based on conventional ultrasound Doppler transfontanel measurement of blood flow in the front cerebral artery with estimation of systolic (Vs), diastolic (Vd), mean velocity (Vm) and calculation of Pourcelot Resistive Index (RI) and Gosling Pulsatility Index (PI) using ultrasound SonoSite Titan (USA) with microconvex probe 5-8 MHz [39].

RI – resistance index of brain arteries by Pourcelot (Pourcelot Resistive Index) [20, 36] according to the equation:

$$RI = (Vs - Vd) / Vs$$

PI – pulsation index of blood flow by Gosling (Gosling Pulsatility Index) [4] according to the equation:

$$PI = (Vs - Vd) / Vm,$$

$$Vm = (Vs + 2 \cdot Vd) / 3$$

Cerebral regional tissue oxygenation index (rScO<sub>2</sub>) by INVOS™ 5100C Cerebral Oximeter (Somanetics, Medtronic, USA) was monitored during the whole 72 hours' period of therapeutic hypothermia [33]. The targeted reference range of rScO<sub>2</sub> was considered within 60-80% [35].

Continuous monitoring of amplitude integrated electroencephalography (aEEG) had been carried out in 72 hours with the application of the diagnostics complex Neuron-Spectrum, "Neurosoft" (Russia).

In addition to the routine lab studies and monitoring the serum concentrations of neuron-specific enolase biomarkers (NSE) and protein S-100 were obtained on day 1 and day 3 of intensive care. Serum levels of the neuron-specific enolase (NSE) and protein S-100 were determined by the immunochemical method with electrochemical luminescent detection (ECLIA, Synevo Laboratory, GCLP 2011, ISO 9001:2000). The referent range according to the standards of the laboratory was considered for NSE up to 16.3 ng/ml, for protein S-100 – up to 0.105 mcg/l. According to Simon-Pimmel J. et al. (2017), in neonates and infants up to 1 month old the upper limit of protein S-100 is <0.51 mcg/l, although according to Abbasoglu A. et al. (2015) the normal value of NSE concentration in term healthy neonates is 18.06±12.83 ng/ml (95% CI 13.94-22.19 ng/ml) [11, 34].

Using simple open randomization all the babies were divided into group of dexmedetomidine (DEX group, n=46) and the control group of standard sedation (n=159). Infants of DEX group received dexmedetomidine in dose of 0.5 mcg/kg/hour via continuous infusion. Neonates of control group (n=71) received morphine infusion in loading dose of 50 mcg/kg not earlier than 30 min followed by maintaining dose of 10-40 mcg/kg/hour, in monotherapy or in combination with sodium oxybutiras (n=78) in dose of 50-100 mg/kg or/and diazepam (n=29) in dose of 0.05-0.1 mg/kg every 4-6 hours if needed.

The end-points included: total days of the respiratory support including invasive and non-invasive ventilation; total days in NICU, and the rate of unfavorable outcome as cerebral leukomalacia.

The diagnosis of cerebral leukomalacia was based on the routine daily neurosonography screening; in case of ultrasound signs of leukomalacia the diagnosis was confirmed by CT/MRI scanning.

The study was approved by Biomedical Ethical Commission of the Dnipropetrovsk Medical Academy, Ukraine. Protocol N 5, 2011 Feb 21.

The statistics analysis of the study data was done using software JASP 0.9.0.1 (Amsterdam, The Netherlands, 2018) in accordance with the generally accepted standards of the mathematical statistics. Before the statistical analysis all the data had been examined for normal distribution using Shapiro-Wilk W-test. For nonparametric data the initial statistical analysis included the calculation of the median M, 25% and 75% percentiles. For the

statistical comparison of the values in the studied groups Mann-Whitney U-test was performed. Confidential interval (CI), hazard ratio (HR) and expected value (EV) were also calculated in appropriate manner. The p-value <0.05 was accepted as significant in all tests.

#### RESULTS AND DISCUSSION

The results of treatment of 205 term neonates were analyzed, the average gestation age in weeks was 39.6±1.4 (37-42); birth weight in grams was 3583±554 (2440-5300). By gender: 128 neonates (62.4%) were boys, and 77 (37.6%) were girls. All the infants were transferred to the NICU from tertiary hospitals level II. 56 babies (27.4%) were admitted to the NICU in 0-6 hours after delivery, during 6-24 hours – 144 (70.2%), in the first 24-72

hours – 5 (2.4%) babies. 28 days' mortality was 3 of 205 babies (1.46%).

First delivery occurred in 82 cases (40%), and 123 (60%) were subsequent. The rate of caesarean sections was 42 of 205 infants (20.5%). From 42 neonates born with Caesarean section, 17 (40.5%) were first born and 25 (59.5%) with subsequent deliveries (p=0.994). The Apgar score at 1<sup>st</sup> minute was 4.04±2.27 points; at 5<sup>th</sup> minute 5.88±1.82 points; at 20<sup>th</sup> minute (estimated only in 56 babies) 6.29±1.19 points. Serum lactate level at admission was 7.93±5.44 [0.9-25.1] mmol/l (normal range 0.9-2.7 mmol/l).

Demographic data of the dexmedetomidine group and the control group at the baseline is presented in Table 1.

Table 1

Demographic data of studied groups at the baseline

	Control group, n=159	DEX group, n=46	P
Gestation, weeks (M±SD [min-max])	39.6±1.5 [36-42]	39.6±1.2 [36-42]	0.852
Birth weight, kg (M±SD [min-max])	3.5±0.5 [2.4-5.3]	3.7±0.6 [2.8-4.8]	0.097
Boys, n (%)	95 (59.8%)	34 (73.9%)	0.080
Girls, n (%)	64 (40.2%)	12 (26.1%)	0.080
Admission 0-6 hours, n (%)	41 (25.8%)	15 (32.6%)	0.360
Admission 6-24 hours, n (%)	113 (71.1%)	31 (67.4%)	0.631
Admission 24-72 hours, n (%)	5 (3.1%)	0	N/A
1st delivery, n (%)	67 (42.1%)	24 (52.2%)	0.228
>1 delivery, n (%)	92 (57.9%)	22 (47.8%)	0.228
C-section, n (%)	32 (20.1%)	9 (19.6%)	0.933
C-section, 1 <sup>st</sup> delivery, n (%)	12 (17.9)	6 (25)	0.454
C-section, >1 <sup>st</sup> delivery, n (%)	20 (21.7)	3 (13.6)	0.395
Apgar, 1 <sup>st</sup> min. (M±SD [min-max])	3.9±2.3 [0-9]	4.5±2.1 [1-8]	0.125
Apgar, 5 <sup>th</sup> min. (M±SD [min-max])	5.8±1.9 [1-9]	6.3±1.7 [2-8]	0.107
Apgar, 20 <sup>th</sup> min (M±SD [min-max])	6.2±1.1 [5-8]	6.5±1.1 [5-8]	0.614
Lactate, mmol/l (M±SD [min-max])	8.5±5.6 [0.9-25.1]	5.2±3.7 [1.0-15.6]	0.019
pH (M±SD [min-max])	7.38±0.1 [7.14-7.69]	7.42±0.1 [7.23-7.73]	0.035

Basing on data of Table 1, there were no statistically significant differences between groups in birth weight, sex, and time of admission, proportion of 1<sup>st</sup> delivery, caesarian section rate and Apgar score at birth. pH was significantly but slightly different between the groups (7.38±0.1 vs. 7.42±0.1, p=0.035). The serum lactate level was significantly

lower in the DEX group (8.5±5.6 vs. 5.2±3.7, p=0.019), but it was noticeably higher than normal range in both groups.

The comparative statistics of the dexmedetomidine group and the control group is presented in Table 2.

Table 2

**Comparison of the intermediate characteristics and short term outcomes of treatment of term neonates with HIE while using dexmedetomidine versus standard sedative agents**

	Control group n=159	DEX group n=46	P
	Median [25%-75%]		
rScO <sub>2</sub> on Day 1, %	79 [68-85]	65 [50-73]	0.012
rScO <sub>2</sub> on Day 2, %	81 [73-93]	74 [67-86]	0.035
MBP, mmHg	53 [46-60]	58 [51-65]	<0.001
Seizures on Day 1, n (%)	77 (48.3%)	2 (4.3%)	<0.001
Extubation (days)	5 [4-8]	5 [4-6]	0.022
Cerebral leukomalacia, n (%)	24 (15.1%)	1 (2.2%)	0.018

Note: n – number of neonates in each group; in [ ] – interquartile range; p – statistical significance of a result; rScO<sub>2</sub> – regional mixed cerebral oxygen saturation; MBP – mean blood pressure.

There was no significant difference between the studied groups in indices RI and PI on day 1 (p=0.944 and p=0.671 respectively) and on day 3 of treatment (p=0.923 and p=0.385 respectively). Similarly, as to NSE and S-100 level there was no difference on day 1 (p=0.524 and p=0.572 respectively) and day 3 (p=0.384 and p=0.353 respectively). It confirms that the severity of the brain damage and the preservation of autoregulation for cerebral blood flow were comparable in both groups, and newborns from two groups were comparable by the degree of hypoxic-ischemic encephalopathy.

No reliable difference was revealed between the DEX group and the control group in total days of the respiratory support (p=0.071) and total days in NICU (p=0.362). But the terms of extubation were significantly different (p=0.022). Prospective data show that DEX patients were significantly more often extubated during 7 days comparing to control group (68% vs. 33% with log-rank p-value of 0.018). Retrospective dataset shows no difference. Pooled analysis demonstrated slightly less difference but the difference of 68% vs. 42% was statistically significant (p=0.011), with hazard ratio of 0.48 which is interpreted that after DEX treatment 52% neonates were still intubated by day 7 (95% CI 0.27-0.86, Cox's regression 0.013). NIRS data of rScO<sub>2</sub> were reliably different between the groups on day 1 (65% vs. 79%, p=0.012) and on day 2 of treatment (74% vs. 81%, p=0.035), but the same was not observed on day 3 of the study (p=0.600).

The data analysis revealed significantly different level of mean blood pressure between both groups. MBP was higher in the DEX group (p<0.001), at the same time infants from DEX group demanded lower doses of dobutamine (EV -1.87; 95% CI -3.25 to -0.48, p=0.009). A significantly lower rate of seizures

was revealed in DEX group on day 1 comparing to control group (p<0.001). And the most essential finding is that the rate of unfavorable outcome such as cerebral leukomalacia was also lower in the DEX group in comparison with the control group (2.2% vs. 15.1%, p=0.018).

Dexmedetomidine appeared to be well-tolerated in neonates with HIE requiring therapeutic hypothermia. No adverse effects of dexmedetomidine such as hypotension or bradycardia were experienced during the study, its infusion rate was not changed during this time. The most probable explanation is the administration of dexmedetomidine in dose not exceeding 0.5 mcg/kg/hour, which matches the results of Estkowski L.M., et al. (2015), who registered the episodes of bradycardia in the range of doses more than 0.6 mcg/kg/hour [12]. Because dexmedetomidine does not have significant effects on respiratory drive, it may present a good sedation option in babies requiring therapeutic hypothermia to preserve their spontaneous breathing pattern. Considering earlier extubation of trachea, the advantage of dexmedetomidine over other sedative agents has been confirmed by the data of O'Mara K., Weiss M.D. (2018) [28].

Data of the NIRS monitoring for cerebral oximetry look quite remarkable and demonstrate the reliably lower rScO<sub>2</sub> indices in the dexmedetomidine group compared to the control group. However the interpretation of the data makes it possible to state that in the DEX group rScO<sub>2</sub> index remained within the normal reference range of 60-80% [38], while in the control group this index insignificantly exceeded the upper limit of the conditionally normal values. It is important to notice that mixed blood saturation rScO<sub>2</sub> supposes the estimation of the balance between oxygen supply and consumption by the

brain. If the decrease in  $rScO_2 < 40\%$  testifies to the condition of severe hypoxia-ischemia, then rather high value of  $rScO_2 > 80\%$  according to Sood B., et al. (2015), Hyttel-Sorensen S., et al. (2017), Garvey A., et al. (2018) and Herold F., et al. (2018) means the decrease in the consumption of oxygen and metabolic slowdown, and the value of  $rScO_2 > 90\%$  is the evidence of the deep metabolism inhibition, stop in oxygen consumption by the brain tissue. Although this interpretation cannot be absolutely fair for the period of therapeutic hypothermia, when the metabolism of the brain is slowed down on purpose and under control [5, 14, 16]. Therefore nowadays the cerebral oximetry in the near-infrared spectrum according to Van Meurs K. and Bonifaci S. (2017) becomes essential as a component of the required neuroresuscitation monitoring [42].

The reliability of the influence of dexmedetomidine on the rate of unfavorable outcome of HIE such as cerebral leukomalacia, and the reliably of a smaller percent of neonates with seizures during

the acute period of HIE in comparison with the control group, requires further investigations, but the results match with the data of the experimental works by Endesfelder S., et al. (2017) and Kurosawa A. et al. (2017) on neuroprotective features of dexmedetomidine [9, 25].

#### CONCLUSIONS

1. Dexmedetomidine is a safe sedative agent with a stable hemodynamic profile, without adverse cerebral influence and possible neuroprotective effects in term infants with HIE, additional to standard therapeutic hypothermia.

2. The determined peculiarities make it possible to use dexmedetomidine in the daily practice of the neonatal intensive care, but additional data needs to be collected before any further conclusions can be drawn.

Conflicts of interest. Author has no conflict of interest to declare.

#### REFERENCES

1. Tkachik SJ. [Forecasting and preventive maintenance perinatal pathologies at anomalies patrimonial activity]. *Health of Woman*. 2016;4(110):168-70. Ukrainian.
2. Weatherall M, Aantaa R, Conti G, Garratt C, Pohjanjousi P, Lewis MA, et al. A multinational, drug utilization study to investigate the use of dexmedetomidine (Dexdor®) in clinical practice in the EU. *Br J Clin Pharmacol*. 2017;83(9):2066-76. doi: <https://doi.org/10.1111/bcp.13293>
3. Chrysostomou C, Schulman SR, Herrera Castellanos M, Cofer BE, Mitra S, da Rocha MG, et al. A phase II/III, multicenter, safety, efficacy, and pharmacokinetic study of dexmedetomidine in preterm and term neonates. *J. Pediatr*. 2014;164(2):276-282.e1-3. doi: <https://doi.org/10.1016/j.jpeds.2013.10.002>
4. Forster DE, Koumoundouros E, Saxton V, Fedai G, Holberton J. Cerebral blood flow velocities and cerebrovascular resistance in normal-term neonates in the first 72 hours. *J. Paediatr Child Health*. 2018;54(1):61-68. doi: <https://doi.org/10.1111/jpc.13663>
5. Hyttel-Sorensen S, Pellicer A, Alderliesten T, Austin T, van Bel F, Benders M, et al. Cerebral near infrared spectroscopy oximetry in extremely preterm infants: phase II randomised clinical trial. *BMJ*. 2015;350(2):g7635. doi: <https://doi.org/10.1136/bmj.g7635>
6. Allanson E, Tunçalp Ö, Gardosi J, Pattinson RC, Erwich JJ, Flenady VJ, et al. Classifying the causes of perinatal death. *Bull World Health Organ*. 2016;94(2):79-79A. doi: <https://doi.org/10.2471/BLT.15.168047>
7. Weerink MA, Struys MM, Hannivoort LN, Barends CR, Absalom AR, Colin P. Clinical pharmacokinetics and pharmacodynamics of dexmedetomidine. *Clin Pharmacokinet*. 2017;56(8):893-913. doi: <https://doi.org/10.1007/s40262-017-0507-7>
8. Arnaez J, García-Alix A, Arca G, Valverde E, Caserío S, Moral MT, et al; Grupo de Trabajo EHI-ESP. Incidence of hypoxic-ischaemic encephalopathy and use of therapeutic hypothermia in Spain. *An Pediatr (Barc)*. 2018;89(1):12-23. doi: <https://doi.org/10.1016/j.anpedi.2017.06.008>
9. Kurosawa A, Sato Y, Sasakawa T, Kunisawa T, Iwasaki H. Dexmedetomidine inhibits epileptiform activity in rat hippocampal slices. *Int J Clin Exp Med*. 2017;10(4):6704-6711. ISSN:1940-5901/IJCEM0046980.
10. Su F, Gastonguay MR, Nicolson SC, DiLiberto M, Ocampo-Pelland A, Zuppa AF. Dexmedetomidine pharmacology in neonates and infants after open heart surgery. *Anesth Analg*. 2016;122(5):1556-66. doi: <https://doi.org/10.1213/ANE.0000000000000869>
11. Dix LM, van Bel F, Lemmers PM. Monitoring cerebral oxygenation in neonates: an update. *Front Pediatr*. 2017;5:46. doi: <https://doi.org/10.3389/fped.2017.00046>
12. Estkowski LM, Morris JL, Sinclair EA. Characterization of dexmedetomidine dosing and safety in neonates and infants. *J Pediatr Pharmacol Ther*. 2015;20(2):112-118. doi: 10.5863/1551-6776-20.2.112
13. Carbajal R, Eriksson M, Courtois E, Boyle E, Avila-Alvarez A, Andersen RD, et al; EUROPAIN Survey Working Group. Sedation and analgesia practices in neonatal intensive care units (EUROPAIN): results from a prospective cohort study. *Lancet Respir Med*. 2015;3(10):796-812. doi: [https://doi.org/10.1016/S2213-2600\(15\)00331-8](https://doi.org/10.1016/S2213-2600(15)00331-8)

14. Garvey AA, Kooi EM, Smith A, Dempsey EM. Interpretation of cerebral oxygenation changes in the preterm infant. *Children (Basel)*. 2018;5(7). pii: E94. doi: <https://doi.org/10.3390/children5070094>
15. Liu L, Oza S, Hogan D, Perin J, Rudan I, Lawn JE, et al. Global, regional, and national causes of child mortality in 2000-2013, with projections to inform post-2015 priorities: an updated systematic analysis. *Lancet*. 2015;385:430-40. doi: [https://doi.org/10.1016/S0140-6736\(14\)61698-6](https://doi.org/10.1016/S0140-6736(14)61698-6)
16. Herold F, Wiegel P, Scholkmann F, Müller NG. Applications of functional near-infrared spectroscopy (fNIRS) neuroimaging in exercise-cognition science: a systematic, methodology-focused review. *J Clin Med*. 2018;7(12). pii: E466. doi: <https://doi.org/10.3390/jcm7120466>
17. Ibrahim M, Jones LJ, Lai N, Tan K. Dexmedetomidine for analgesia and sedation in newborn infants receiving mechanical ventilation (Protocol). *Cochrane Database Syst Rev*. 2016;9:CD012361. doi: <https://doi.org/10.1002/14651858.CD012361>
18. Torbensoen VE, Tolcher MC, Nesbitt KM, Colby CE, EL-Nashar SA, Gostout BS, et al. Intrapartum factors associated with neonatal hypoxic ischemic encephalopathy: a case-controlled study. *BMC Pregnancy Childbirth*. 2017;17:415-422. doi: <https://doi.org/10.1186/s12884-017-1610-3>
19. Lee AC, Kozuki N, Blencowe H, Vos T, Bahalim A, Darmstadt GL, et al. Intrapartum-related neonatal encephalopathy incidence and impairment at regional and global levels for 2010 with trends from 1990. *Pediatr Res*. 2013;74(1):50-72. doi: <https://doi.org/10.1038/pr.2013.206>
20. Kumar AS, Chandrasekaran A, Asokan R, Gopinathan K. Prognostic value of resistive index in neonates with hypoxic ischemic encephalopathy. *Indian Pediatr*. 2016;53:1079-1082. PMID: 27889713.
21. Mahmoud M, Mason KP. Dexmedetomidine: review, update, and future considerations of paediatric perioperative and periprocedural applications and limitations. *BJA: British Journal of Anaesthesia*. 2015;115(2):171-82. doi: <https://doi.org/10.1093/bja/aev226>
22. Mayock DE, Gleason CA. Pain and sedation in the NICU. *NeoReviews*. 2013;14:e22-e31. doi: <https://doi.org/10.1542/neo.14-1-e22>
23. Borenstein-Levin L, Synnes A, Grunau RE, Miller SP, Yoon EW, Shah PS. Narcotics and sedative use in preterm neonates. *J Pediatr*. 2017;180:92-98.e1. doi: <https://doi.org/10.1016/j.jpeds.2016.08.031>
24. Tagin M, Abdel-Hady H, Rahman S, Azzopardi DV, Gunn AJ. Neuroprotection for perinatal hypoxic ischemic encephalopathy in low- and middle-income countries. *Journal of Pediatrics*. 2015;167(1):25-28. doi: <https://doi.org/10.1016/j.jpeds.2015.02.056>
25. Endesfelder S, Makki H, von Haefen C, Spies CD, Bühner C, Sifringer M. Neuroprotective effects of dexmedetomidine against hyperoxia-induced injury in the developing rat brain. *PLoS One*. 2017;12(2):e0171498. doi: <https://doi.org/10.1371/journal.pone.0171498>
26. Wu J, Vogel T, Gao X, Lin B, Kulwin C, Chen J. Neuroprotective effect of dexmedetomidine in a murine model of traumatic brain injury. *Scientific Reports*. 2018;8:4935. doi: <https://doi.org/10.1038/s41598-018-23003-3>
27. Zhang MH, Zhou XM, Cui JZ, Wang KJ, Feng Y, Zhang HA. Neuroprotective effects of dexmedetomidine on traumatic brain injury: Involvement of neuronal apoptosis and HSP70 expression. *Mol Med Rep*. 2018;17(6):8079-86. doi: <https://doi.org/10.3892/mmr.2018.8898>
28. O'Mara K, Weiss MD. Dexmedetomidine for sedation of neonates with HIE undergoing therapeutic hypothermia: a single-center experience. *AJP Rep*. 2018;8(3):e168-e173. doi: <https://doi.org/10.1055/s-0038-1669938>
29. Parikh P, Juul SE. Neuroprotective strategies in neonatal brain injury. *The Journal of Pediatrics*. 2018;192:22-32. doi: <https://doi.org/10.1016/j.jpeds.2017.08.031>
30. Perez-Zoghbi JF, Zhu W, Grafe MR, Brambrink AM. Dexmedetomidine-mediated neuroprotection against sevoflurane-induced neurotoxicity extends to several brain regions in neonatal rats. *BJA: British Journal of Anaesthesia*. 2017;119(3):506-16. doi: <https://doi.org/10.1093/bja/aex222>
31. Simiyu IN, Mchaile DN, Katsonger K, Philemon RN, Msuya SE. Prevalence, severity and early outcomes of hypoxic ischemic encephalopathy among newborns at a tertiary hospital, in northern Tanzania. *BMC Pediatr*. 2017;17(1):131. doi: <https://doi.org/10.1186/s12887-017-0876-y>
32. Pullen LC. Dexmedetomidine effective sedative for neonates [Internet]. 2013 [cited 2019 Feb 19]. Available from: <https://www.medscape.com/viewarticle/818075>
33. Abbasoglu A, Sarialioglu F, Yazici N, Bayraktar N, Haberal A, Erbay A. Serum neuron-specific enolase levels in preterm and term newborns and in infants 1-3 months of age. *Pediatrics and Neonatology*. 2015;56(2):114-119. doi: <https://doi.org/10.1016/j.pedneo.2014.07.005>
34. Baik N, Urlesberger B, Schwaberg B, Schmölder GM, Mileder L, Avian A, Pichler G. Reference ranges for cerebral tissue oxygen saturation index in term neonates during immediate neonatal transition after birth. *Neonatology*. 2015;108(4):283-286. doi: <https://doi.org/10.1159/000438450>
35. Simon-Pimmel J, Lorton F, Masson D, Bouvier D, Hanf M, Gras-Le Guen C. Reference ranges for serum S100B neuroprotein specific to infants under four months of age. *Clinical Biochemistry*. 2017;50(18):1056-60. doi: <https://doi.org/10.1016/j.clinbiochem.2017.08.014>
36. Zamora CA, Oshmyansky A, Bembea M, Berkowitz I, Alqahtani E, Liu S, et al. Resistive index variability in anterior cerebral artery measurements during daily transcranial duplex sonography. *J Ultrasound Med*. 2016;35:2459-65. doi: <https://doi.org/10.7863/ultra.15.09046>
37. Romantsik O, Calevo MG, Norman E, Bruschetini M. Clonidine for sedation and analgesia for neonates receiving mechanical ventilation. *Cochrane Database Syst*

Rev. 2017;5:CD012468.

doi: <https://doi.org/10.1002/14651858.CD012468.pub2>

38. Sood BG, McLaughlin K, Cortez J. Near-infrared spectroscopy: applications in neonates. *Semin Fetal Neonatal Med.* 2015;20(3):164-72. doi: <https://doi.org/10.1016/j.siny.2015.03.008>

39. Sorokan ST, Jefferies AL, Miller SP. Canadian Paediatric Society, Fetus and Newborn Committee. Imaging the term neonatal brain. *Paediatr Child Health.* 2018;23(5):322-8.

doi: <https://doi.org/10.1093/pch/pxx161>

40. Su F, Nicolson SC, Zuppa AF. A dose-response study of dexmedetomidine administered as the primary sedative in infants following open heart surgery. *Pediatr Crit Care Med.* 2013;14(5):499-507. doi: <https://doi.org/10.1097/PCC.0b013e31828a8800>

41. UNICEF. Neonatal mortality [Internet]. 2018 [cited 2019 Jan 31]. Available from: <https://data.unicef.org/topic/child-survival/neonatal-mortality/>

42. Van Meurs KP, Bonifacio SL. Brain-focused care in the neonatal intensive care unit: the time has come. *J Pediatr (Rio J).* 2017;93(5):439-441. doi: <https://doi.org/10.1016/j.jped.2017.03.002>

43. Wang Y, Han R, Zuo Z. Dexmedetomidine-induced neuroprotection: is it translational? *Transl Perioper Pain Med.* 2016;1(4):15-19. PMID: 28217717; PMCID: PMC5310645.

44. Wenhao W. Model-based evaluation of dose regimens in preterm and term neonates for dexmedetomidine and vancomycin. *Digitala Vetenskapliga Arkivet [Internet].* 2017 Available from: <http://www.diva-portal.org/smash-record.jsf?pid=diva2%3A1140628&dsid=1932>

## СПИСОК ЛІТЕРАТУРИ

1. Ткачик С. Я. Прогнозування та профілактика перинатальної патології при аномаліях пологової діяльності. *Здоров'я жінчини.* 2016. № 4. С.168-170. doi: [nbuv.gov.ua/UJRN/Zdzh\\_2016\\_4\\_36](https://doi.org/10.1016/j.jped.2013.10.002).

2. A multinational, drug utilization study to investigate the use of dexmedetomidine (Dexdor®) in clinical practice in the EU / Weatherall M. et al. *Br. J. Clin. Pharmacol.* 2017. Vol. 83, N 9. P. 2066-2076. DOI: <https://doi.org/10.1111/bcp.13293>

3. A phase II/III, multicenter, safety, efficacy, and pharmacokinetic study of dexmedetomidine in preterm and term neonates / Chrysostomou C. et al. *J. Pediatr.* 2014. Vol. 164, N 2. P. 276-282.e1-3. DOI: <https://doi.org/10.1016/j.jpeds.2013.10.002>

4. Cerebral blood flow velocities and cerebrovascular resistance in normal-term neonates in the first 72 hours / Forster D. E. et al. *J. Paediatr. Child Health.* 2018. Vol. 54, N 1. P. 61-68. DOI: <https://doi.org/10.1111/jpc.13663>

5. Cerebral near infrared spectroscopy oximetry in extremely preterm infants: phase II randomised clinical trial / Hyttel-Sorensen S. et al. *BMJ.* 2015. Vol. 350, N 2. g7635. DOI: <https://doi.org/10.1136/bmj.g7635>

6. Classifying the causes of perinatal death / Allanson E. et al. *Bull. World Health Organ.* 2016. Vol. 94, N 2. P. 79-79A. DOI: <https://doi.org/10.2471/BLT.15.168047>.

7. Clinical pharmacokinetics and pharmacodynamics of dexmedetomidine / Weerink M. A. et al. *Clin. Pharmacokinet.* 2017. Vol. 56, N 8. P. 893-913. DOI: <https://doi.org/10.1007/s40262-017-0507-7>

8. Grupo de Trabajo EHI-ESP. Incidence of hypoxic-ischaemic encephalopathy and use of therapeutic hypothermia in Spain / Arnaez J. et al. *An. Pediatr. (Barc.).* 2018. Vol. 89, N 1. P. 12-23. DOI: <https://doi.org/10.1016/j.anpedi.2017.06.008>

9. Dix L. M., van Bel F., Lemmers P. M. Monitoring cerebral oxygenation in neonates: an

update. *Front. Pediatr.* 2017. Vol. 5. P. 46. DOI: <https://doi.org/10.3389/fped.2017.00046>

10. Dexmedetomidine inhibits epileptiform activity in rat hippocampal slices / Kurosawa A. et al. *Int. J. Clin. Exp. Med.* 2017. Vol. 10, N 4. P. 6704-6711. ISSN: 1940-5901/IJCEM0046980.

11. Dexmedetomidine pharmacology in neonates and infants after open heart surgery / Su F. et al. *Anesth. Analg.* 2016. Vol. 122, N 5. P. 1556-1566. DOI: <https://doi.org/10.1213/ANE.0000000000000869>

12. Estkowski L. M., Morris J. L., Sinclair E. A. Characterization of dexmedetomidine dosing and safety in neonates and infants. *J. Pediatr. Pharmacol. Ther.* 2015. Vol. 20, N 2. P. 112-118. DOI: 10.5863/1551-6776-20.2.112

13. EUROPAIN Survey Working Group. Sedation and analgesia practices in neonatal intensive care units (EUROPAIN): results from a prospective cohort study / Carbajal R. et al. *Lancet Respir. Med.* 2015. Vol. 3, N 10. P. 796-812. DOI: [https://doi.org/10.1016/S2213-2600\(15\)00331-8](https://doi.org/10.1016/S2213-2600(15)00331-8)

14. Garvey A. A., Kooi E. M., Smith A., Dempsey E. M. Interpretation of cerebral oxygenation changes in the preterm infant. *Children (Basel).* 2018. Vol. 5, N 7. pii: E94. DOI: <https://doi.org/10.3390/children5070094>

15. Global, regional, and national causes of child mortality in 2000-2013, with projections to inform post-2015 priorities: an updated systematic analysis / Liu L. et al. *Lancet.* 2015. Vol. 385. P. 430-440. DOI: [https://doi.org/10.1016/S0140-6736\(14\)61698-6](https://doi.org/10.1016/S0140-6736(14)61698-6)

16. Herold F., Wiegel P., Scholkmann F., Müller N. G. Applications of functional near-infrared spectroscopy (fNIRS) neuroimaging in exercise-cognition science: a systematic, methodology-focused review. *J. Clin. Med.* 2018. Vol. 7, N 12. pii: E466. DOI: <https://doi.org/10.3390/jcm7120466>

17. Ibrahim M., Jones L. J., Lai N., Tan K. Dexmedetomidine for analgesia and sedation in newborn infants



receiving mechanical ventilation (Protocol). *Cochrane Database Syst. Rev.* 2016. Vol. 9. CD012361. DOI: <https://doi.org/10.1002/14651858.CD012361>.

18. Intrapartum factors associated with neonatal hypoxic ischemic encephalopathy: a case-controlled study / Torbenson V.E. et al. *BMC Pregnancy Childbirth.* 2017. Vol. 17. P. 415-422. DOI: <https://doi.org/10.1186/s12884-017-1610-3>

19. Intrapartum-related neonatal encephalopathy incidence and impairment at regional and global levels for 2010 with trends from 1990 / Lee A. C. et al. *Pediatr. Res.* 2013. Vol. 74, N 1. P. 50-72. DOI: <https://doi.org/10.1038/pr.2013.206>

20. Kumar A. S., Chandrasekaran A., Asokan R., Gopinathan K. Prognostic value of resistive index in neonates with hypoxic ischemic encephalopathy. *Indian Pediatr.* 2016. Vol. 53. P. 1079-1082. PMID: 27889713.

21. Mahmoud M., Mason K. P. Dexmedetomidine: review, update, and future considerations of paediatric perioperative and periprocedural applications and limitations. *BJA: British J. of Anaesthesia.* 2015. Vol. 115, N 2. P. 171-182. DOI: <https://doi.org/10.1093/bja/aev226>

22. Mayock D. E., Gleason C. A. Pain and sedation in the NICU. *NeoReviews.* 2013. Vol. 14. e22-e31. DOI: <https://doi.org/10.1542/neo.14-1-e22>

23. Narcotics and sedative use in preterm neonates / Borenstein-Levin L. et al. *J. Pediatr.* 2017. Vol. 180. P. 92-98.e1. DOI: <https://doi.org/10.1016/j.jpeds.2016.08.031>

24. Neuroprotection for perinatal hypoxic ischemic encephalopathy in low- and middle-income countries / Tagin M. et al. *J. of Pediatrics.* 2015. Vol. 167, N 1. P. 25-28. DOI: <https://doi.org/10.1016/j.jpeds.2015.02.056>

25. Neuroprotective effects of dexmedetomidine against hyperoxia-induced injury in the developing rat brain / Endesfelder S. et al. *PLoS One.* 2017. Vol. 12, N 2. P. e0171498. DOI: <https://doi.org/10.1371/journal.pone.0171498>

26. Wu J. et al. Neuroprotective effect of dexmedetomidine in a murine model of traumatic brain injury. *Scientific Reports.* 2018. Vol. 8. P. 4935. DOI: <https://doi.org/10.1038/s41598-018-23003-3>

27. Neuroprotective effects of dexmedetomidine on traumatic brain injury: Involvement of neuronal apoptosis and HSP70 expression / Zhang M. H. et al. *Mol. Med. Rep.* 2018. Vol. 17, N 6. P. 8079-8086. DOI: <https://doi.org/10.3892/mmr.2018.8898>

28. O'Mara K., Weiss M. D. Dexmedetomidine for sedation of neonates with HIE undergoing therapeutic hypothermia: a single-center experience. *AJP Rep.* 2018. Vol. 8, N 3. e168-e173. DOI: <https://doi.org/10.1055/s-0038-1669938>

29. Parikh P., Juul S. E. Neuroprotective strategies in neonatal brain injury. *The J. of Pediatrics.* 2018. Vol. 192. P. 22-32. DOI: <https://doi.org/10.1016/j.jpeds.2017.08.031>

30. Perez-Zoghbi J. F., Zhu W., Grafe M. R., Brambrink A. M. Dexmedetomidine-mediated neuroprotection against sevoflurane-induced neurotoxicity extends to several brain regions in neonatal rats. *BJA: British J. of Anaesthesia.* 2017. Vol. 119, N 3. P. 506-516. DOI: <https://doi.org/10.1093/bja/aex222>

31. Prevalence, severity and early outcomes of hypoxic ischemic encephalopathy among newborns at a tertiary hospital, in northern Tanzania / Simiyu I. N., et al. *BMC Pediatr.* 2017. Vol. 17, N 1. P. 131. DOI: <https://doi.org/10.1186/s12887-017-0876-y>

32. Pullen L. C. Dexmedetomidine effective sedative for neonates. 2013. URL: <https://www.medscape.com/viewarticle/818075>. (Last accessed: 19.02.2018).

33. Serum neuron-specific enolase levels in preterm and term newborns and in infants 1-3 months of age / Abbasoglu A. et al. *Pediatrics and Neonatology.* 2015. Vol. 56, N 2. P. 114-119. DOI: <https://doi.org/10.1016/j.pedneo.2014.07.005>

34. Reference ranges for cerebral tissue oxygen saturation index in term neonates during immediate neonatal transition after birth / Baik N. et al. *Neonatology.* 2015. Vol. 108, N 4. P. 283-286. DOI: <https://doi.org/10.1159/000438450>.

35. Reference ranges for serum S100B neuroprotein specific to infants under four months of age / Simon-Pimmel J. et al. *Clinical Biochemistry.* 2017. Vol. 50, N 18. P. 1056-1060. DOI: <https://doi.org/10.1016/j.clinbiochem.2017.08.014>

36. Resistive index variability in anterior cerebral artery measurements during daily transcranial duplex sonography / Zamora C. A. et al. *J. Ultrasound Med.* 2016. Vol. 35. P. 2459-2465. DOI: <https://doi.org/10.7863/ultra.15.09046>

37. Romantsik O., Calevo M. G., Norman E., Bruschettini M. Clonidine for sedation and analgesia for neonates receiving mechanical ventilation. *Cochrane Database Syst. Rev.* 2017. Vol. 5. CD012468. DOI: <https://doi.org/10.1002/14651858.CD012468.pub2>

38. Sood B. G., McLaughlin K., Cortez J. Near-infrared spectroscopy: applications in neonates. *Semin. Fetal Neonatal Med.* 2015. Vol. 20, N 3. P. 164-172. DOI: <https://doi.org/10.1016/j.siny.2015.03.008>

39. Sorokan S. T., Jefferies A. L., Miller S. P. Canadian Paediatric Society, Fetus and Newborn Committee. Imaging the term neonatal brain. *Paediatr. Child Health.* 2018. Vol. 23, N 5. P. 322-328. DOI: <https://doi.org/10.1093/pch/pxx161>

40. Su F., Nicolson S. C., Zuppa A. F. A dose-response study of dexmedetomidine administered as the primary sedative in infants following open heart surgery. *Pediatr. Crit. Care Med.* 2013. Vol. 14, N 5. P. 499-507. DOI: <https://doi.org/10.1097/PCC.0b013e31828a8800>

41. UNICEF. Neonatal mortality. 2018. URL: <https://data.unicef.org/topic/child-survival/neonatal-mortality/>. (Last accessed: 13.01.2018).

42. Van Meurs K. P., Bonifacio S. L. Brain-focused care in the neonatal intensive care unit: the time has

come. *J. Pediatr. (Rio J.)*. 2017. Vol. 93, N 5. P. 439-441. DOI: <https://doi.org/10.1016/j.jpmed.2017.03.002>

43. Wang Y., Han R., Zuo Z. Dexmedetomidine-induced neuroprotection: is it translational? *Transl. Perioper. Pain Med.* 2016. Vol. 1, N 4. P. 15-19. PMID: 28217717, PMCID: PMC5310645.

44. Wenhao W. Model-based evaluation of dose regimens in preterm and term neonates for dexmedetomidine and vancomycin. *Digitala Vetenskapliga Arkivet*. 2017. URL: <http://www.diva-portal.org/smash/record.jsf?pid=diva2%3A1140628&dswid=1932>.

Стаття надійшла до редакції  
18.03.2019



UDC 616.131-007.22-053.32-08:615.456

<https://doi.org/10.26641/2307-0404.2019.2.170125>

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## MANAGEMENT OF PATENT DUCTUS ARTERIOSUS IN PREMATURE INFANTS

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**Цитування:** *Медичні перспективи*. 2019. Т. 24, № 2. С. 33-40

**Cited:** *Medicni perspektivi*. 2019;24(2):33-40

**Key words:** *patent ductus arteriosus, restrictive infusion therapy, cox inhibitors, premature newborns*

**Ключові слова:** *відкрита артеріальна протока, рестриктивна інфузійна терапія, інгібітори ЦОГ, недоношені новонароджені*

**Ключевые слова:** *открытый артериальный проток, рестриктивная инфузионная терапия, ингибиторы ЦОГ, недоношенные новорожденные*

**Abstract.** Management of patent ductus arteriosus in premature infants. Obolonskyi A., Snisar V., Surkov D., Obolonska O., Kapustina O., Dereza K. Closure of hemodynamically significant patent ductus arterios (HSPDA) is one of the most important questions in modern neonatal intensive care, especially for preterm babies. Long-term functioning of the hemodynamically significant arterial duct leads to a large number of complications in premature babies, such as: bronchopulmonary dysplasia, periventricular leucomalacia, intraventricular hemorrhage, retinopathy of the premature. To prevent all these complications, the PDA should be closed pharmacologically or surgically as soon as possible without any hesitation. COX inhibitors are commonly used nowa days. Ibuprofen and indomethacin show the equal efficacy and no significant adverse events. But some patients still need surgical treatment. The aim of the study was to determine the feasibility, effectiveness and safety of using various volumes of infusion in combination