Dear Editor

We read with major interest the letter of Dr N.T. Sajit and colleagues on the role of caffeine for apnoeas in bronchiolitis.[1] It is well-known that recurrent apnoeas in high risk infants with severe (mostly RSV-related) bronchiolitis increases the need for invasive respiratory support and thus inducing transfer to a neonatal or paediatric intensive care unit. We like to report here a similar highly positive experience with the use of a single loading dose of doxapram (2.5 mg/kg IV over 15 minutes) without maintenance therapy in two outborn infants of less than 28 days old who were transferred to our intensive care unit for respiratory support because of severe and recurrent apnoeas related to RSV bronchiolitis. The refractory apnoea syndrome ceased completely and didn’t recur. Both infants escaped from invasive endotracheal ventilation and retrospectively we estimated that they probably could have remained within the referring general hospital as the result of the single dose of doxapram treatment. Doxapram is often used as a second line respiratory stimulant in the treatment of apnoea of prematurity.[2] It seems also useful in the treatment of postoperative apnoea in preterm graduates. We feel that doxapram is a relatively simple treatment option in a general hospital for apnoeas in bronchiolitis avoiding transfer for invasive respiratory support. In concert with Dr N.T. Sajit and colleagues we recommend randomised controlled trials of respiratory stimulants as an alternative for invasive respiratory support in recurrent apnoeas owing to severe bronchiolitis in high risk infants.

Competing interest
none declared

References


Piet Vanhaesebrouck and Koenraad Smets NICU Gent University Hospital