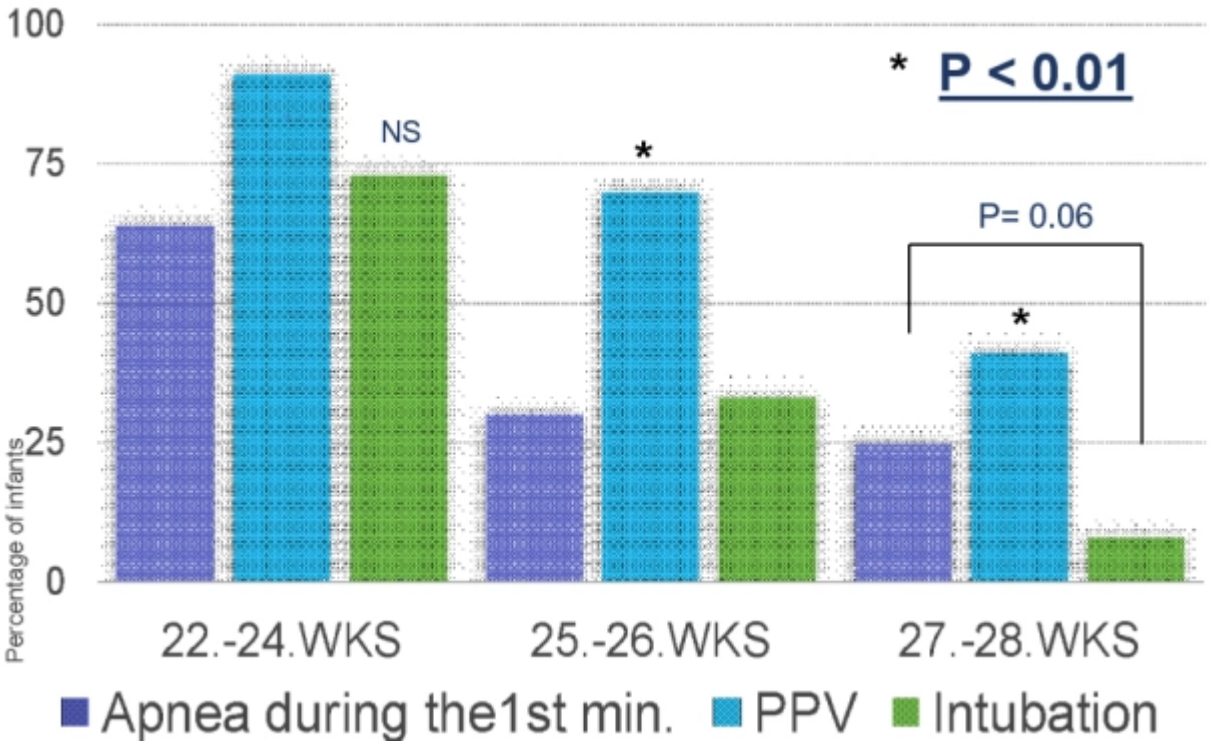
កាណុងច្រមុះហូរហ្មោលខ្ពស់ សម្រាប់ការគាំទ្រផ្លូវដង្ហើមបឋមក្នុងទារកមិនគ្រប់ខែ> 28 សប្តាហ៍

28 សប្តាហ៍

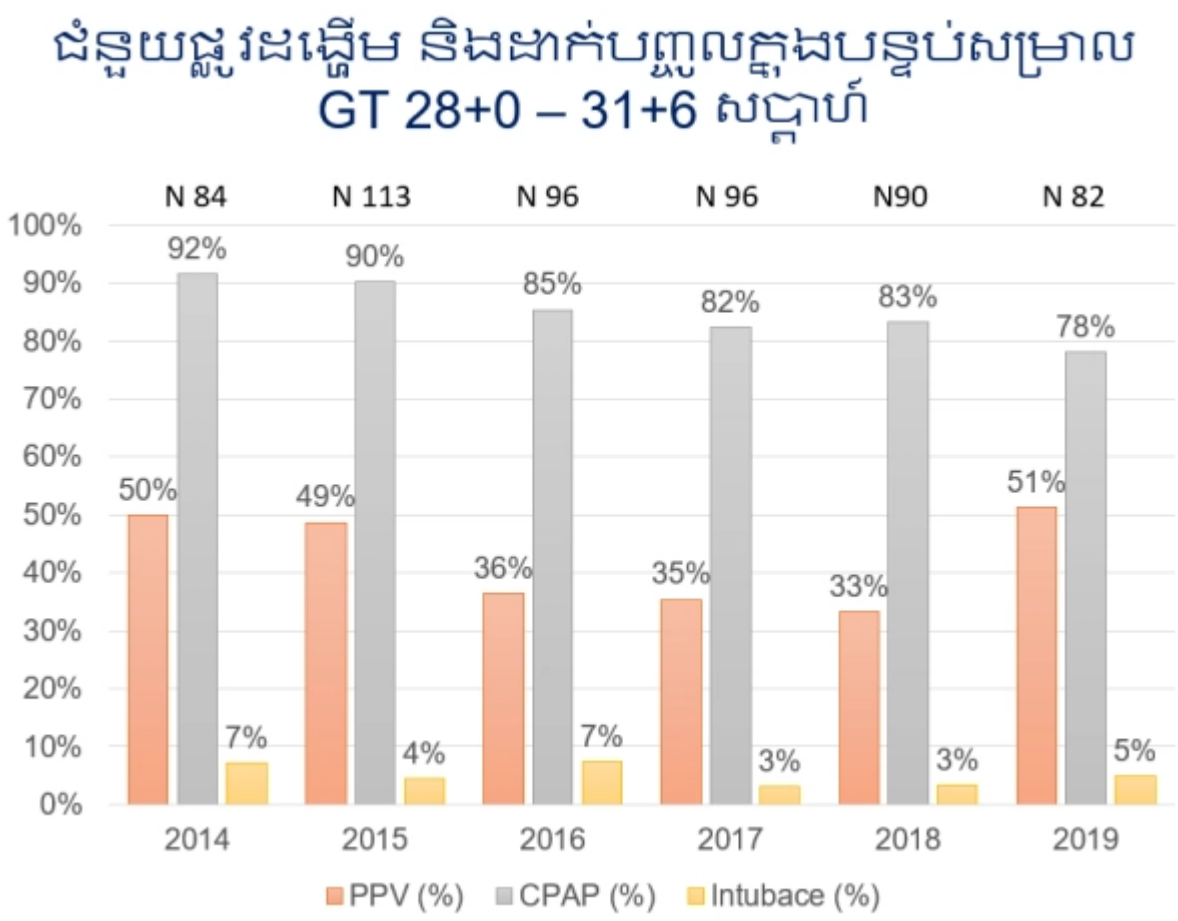
និក្ខេបបទនៃការថែទាំមុនអាយុ

- ការកើតមិនគ្រប់ខែគឺជាក្រុមតំណពូជច្រើនបំផុតនៃអ្នកជំងឺទារក
- ការថែទាំផ្ទាល់ខ្លួន
- ឯកសារយោងនៃនីតិវិធីរាតត្បាតតិចតួចបំផុត។
- ការលួងលោមសម្រាប់អ្នកជំងឺរួមគ្នាជាមួយឪពុកម្តាយ

PPV និង intubation នៅក្នុងបន្ទប់សម្រាល



Lamberská T 2016

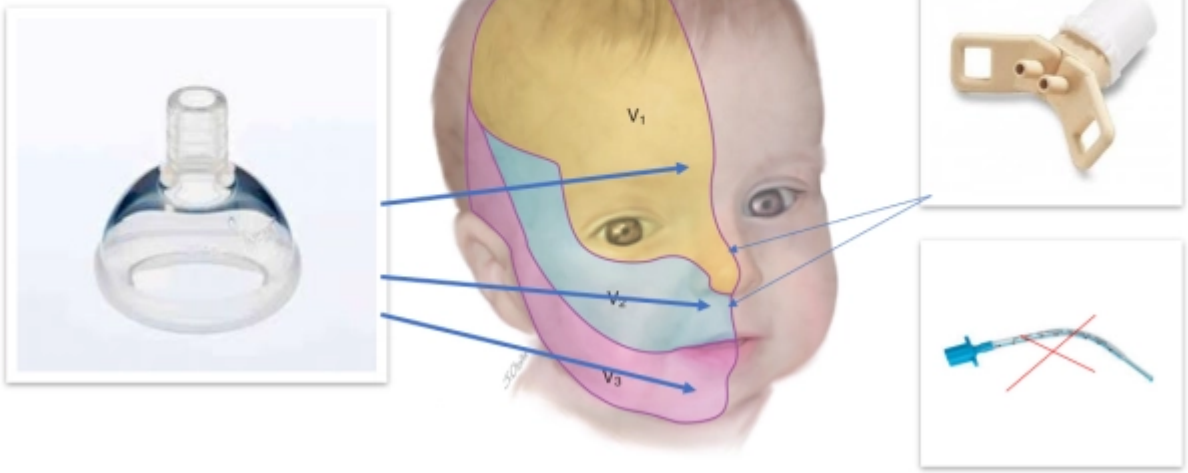


VFN J Smíšek

Trigemino - ការឆ្លុះបេះដូង

ការឆ្លុះបញ្ចាំង ពីការមុជទឹក

BRADYCARDIA, APNOE



Cardia

Available online at www.sciencedirect.com

Resuscitation

journal homepage: www.elsevier.com/locate/resuscitation

Clinical paper

The effect of a face mask for respiratory support on breathing in preterm infants at birth

Kristel L.A.M. Kuypers[a,], Tereza Lamberska[b], Tessa Martherus[a], Janneke Dekker[a], Stefan Bdhringer[c], Stuart B. Hooper[d,e], Richard Plavka[b], Arjan B. te Pas[a]*

Table 1 – Characteristics of the patients.

Patients' characteristics	All infants N = 429
Gestational age in weeks, median (IQR)	28^{+6} (27^{+1} – 30^{+4})
Birth weight in grams, mean ± SD	1176 ± 377
Males, n (%)	229 (53)
Antenatal corticosteroids, n (%)	226 (53)
Caesarean delivery, n (%)	257 (60)
General anaesthesia, n (%)	52 (12)
Placental transfusion, n (%)	104 (59)[a]
Apgar score 1 min, median (IQR)	6 (3–7)
Apgar score 5 min, median (IQR)	8 (7–9)
Umbilical cord blood pH, mean ± SD	7.27 ± 0.12[b]

Table 2 – Breathing before and after face mask application.

Outcome	Signs of breathing before face mask (n = 368)	No signs of breathing before face mask (n = 61)	p-Value
Thorax excursions after face mask, n (%)			<0.001*
• Visible (continued breathing)	171 (46)	0 (0)	
• Not visible (stopped breathing[b])	197 (54)	61 (100)	
PPV is given, n (%)	183 (50)	57 (93)	<0.001*

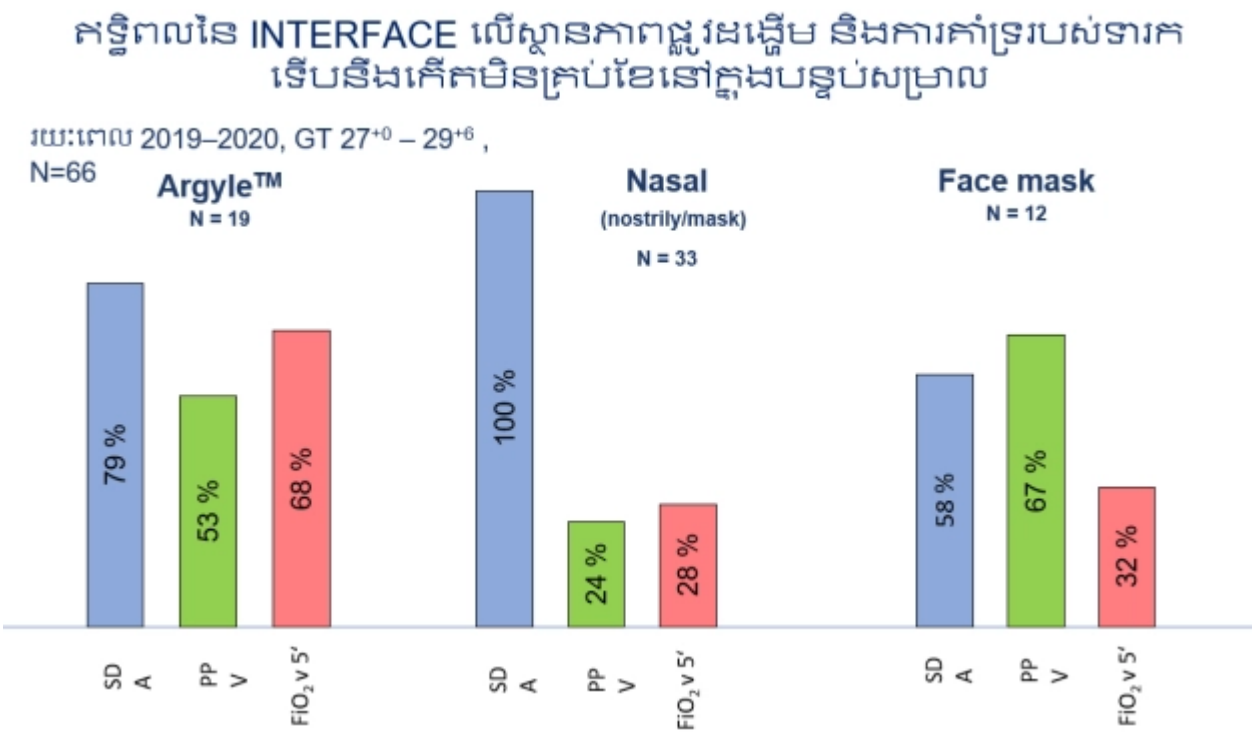
PPV – positive pressure ventilation.

Table 4 – Logistic regression analyse of infants who were initially breathing.

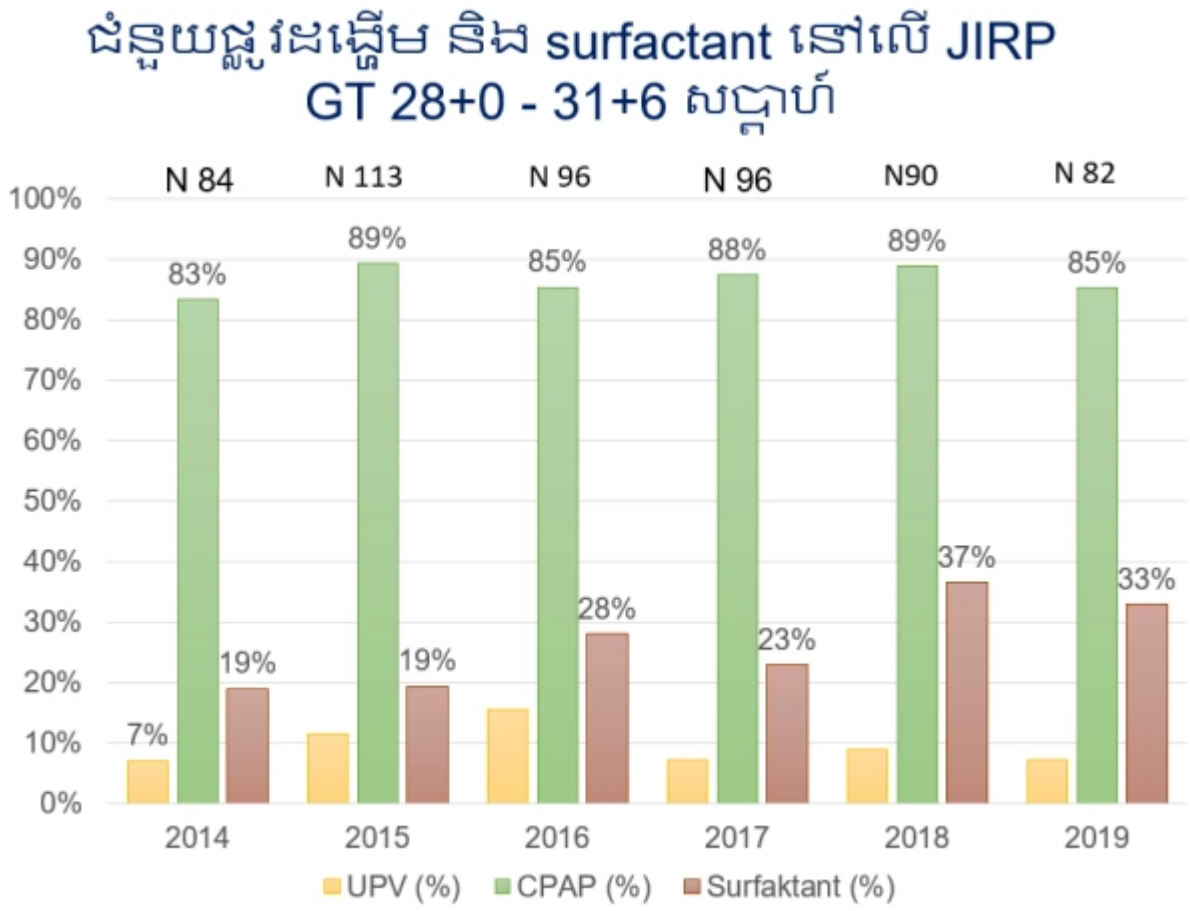
	Odds ratio	95% CI odds ratio lower	upper	p-Value
Gestational age in weeks	1.424	1.281	1.583	<0.001
Males	0.709	0.468	1.075	0.11
General anaesthesia	0.587	0.293	1.175	0.13

Note: $\chi 2(3) = 58.936$, $p < 0.05$, R^2 (Nagelkerke):0.174, correctly classified in 65.3% of the infants.

Respiratory



VFN K. Dunajová



VFN J Smíšek

គោលការណ៍ណែនាំរួមរបស់អឺរ៉ុបស្តីពីការគ្រប់គ្រងរោគសញ្ញានៃជំងឺផ្លូវដង្ហើម - ការធ្វើបច្ចុប្បន្នភាពឆ្នាំ 2019

អនុសាសន៍

CPAP គួរតែត្រូវបានចាប់ផ្តើមពីកំណើតនៅក្នុងទារកទាំងអស់ដែលមានហានិភ័យនៃ RDS ដូចជាអ្នកដែលមានគភ៌ <30 សប្តាហ៍ដែលមិនត្រូវការ intubation សម្រាប់ស្ថេរភាព (**A1**) ។

CPAP ជាមួយនឹង surfactant សង្គ្រោះដំបូងត្រូវបានចាត់ទុកថាជាការគ្រប់គ្រងល្អបំផុតសម្រាប់ទារកដែលមាន RDS (**A1**) ។

ក្នុងអំឡុងពេលផ្តាច់ដោះ HFNC អាចត្រូវបានប្រើជាជម្រើសជំនួស CPAP សម្រាប់ទារកមួយចំនួនដែលមានអត្ថប្រយោជន៍នៃការប៉ះទង្គិចច្រមុះតិច (**B2**)។

សេចក្តីសង្ខេប - ការប្រើប្រាស់បឋម HFNC

- CPAP គឺប្រសើរជាង HFNC ក្នុងការព្យាបាលបឋម RDS ក្នុងទារក > 28 សប្តាហ៍
- HFNC បរាជ័យក្នុង 25% (CPAP 15%) ដោយគ្មានការគ្រប់គ្រង surfactant ពីមុន (FiO2 ≥ 0.4) (ការសាកល្បង HIPSTER និង HUNTER ។ NEJM 2016, NEJM 2019)
- ការប្រើប្រាស់ច្បាប់ 30/30” អាចកាត់បន្ថយហានិភ័យនៃការបរាជ័យ។ Manley ឆ្នាំ 2018
- មិនមានភាពខុសប្លែកគ្នារវាង CPAP និង HFNC ក្នុងការប្រើប្រាស់បឋមនៅពេលដែល surfactant ត្រូវបានគ្រប់គ្រងមុនពេលបំពេញលក្ខណៈវិនិច្ឆ័យបរាជ័យ។ ការពិនិត្យឡើងវិញជាប្រព័ន្ធ និងការវិភាគមេតា Fleeman N 2019, Hong H 2018
- សម្ពាធ pharyngeal ប្រែប្រួល ហើយត្រូវបានជះឥទ្ធិពលយ៉ាងខ្លាំងដោយទីតាំងមាត់ លំហូរ និងសមាមាត្រ nares/ prongs ។ Liew Z et al 2019, Mazmanyan P 2020
- ទិន្នន័យអំពីការប្រើប្រាស់ HFNC ការប្រើប្រាស់នៅក្នុង DR ត្រូវបានកំណត់។ Reynolds P 2015

ផ្សារទំនើបផាល

- ការប្រើប្រាស់គ្លីនិកនៃ HFNC កំពុងកើនឡើង។ មានភាពខុសប្លែកគ្នាច្រើនក្នុងការប្រើប្រាស់ HFNC: ការចង្អុលបង្ហាញ លំហូរ និង cannulas ។ Eklund WM 2018
- Vapotherm HFNC បង្កើតកម្រិតសំលេងរំខានខ្ពស់ជាង (ប្រហែល>5-10 dB) ជាងលំហូរបន្ត CPAP (លំហូរបន្ត) Konig K 2013
- HFNC មានភាពអត់ធ្មត់ជាងដោយឪពុកម្តាយ និងបុគ្គលិកគិលានុបដ្ឋាយិកា។ Klingenberg C 2015
- ឥទ្ធិពលវិជ្ជមានលើ GIT គឺមិនច្បាស់លាស់។

Table 4. GRADE Ratings for HHHFNC Versus NCPAP (Analysis of Primary Respiratory Support: Preterm Infants with No Prior Mechanical Endotracheal Ventilation)

Certainty assessment a						No. of patients		Effect		Overall certainty of evidence (quality)
Outcome	No. of studies	Risk of bias	Inconsistency	Indirectness	Imprecision	HHHFNC	NCPAP	Relative (95% CI)	Absolute (95% CI)	
Intubation/ critical	6	Not serious	Not serious	Not serious	Serious b	90/704 (12.8%)	81/728 (11.1%)	RR 1.15 (0.87 to 1.52)	17 more per 1,000 (from 14 fewer to 58 more)	⊕⊕⊕◯ Moderate
BPD/ important	6	Not serious	Not serious	Not serious	Serious b	27/348 (7.8%)	24/359 (6.7%)	RR 1.14 (0.75 to 1.75)	9 more per 1,000 (from 17 fewer to 50 more)	⊕⊕⊕◯ Moderate
Death/ critical	7	Not serious	Not serious	Not serious	Serious b	5/717 (0.7%)	5/741 (0.7%)	RR 1.03 (0.32 to 3.33)	0 fewer per 1,000 (from 5 fewer to 16 more)	⊕⊕⊕◯ Moderate
Air leak/ important	6	Not serious	Not serious	Not serious	Serious b	15/702 (2.1%)	18/727 (2.5%)	RR 0.88 (0.46 to 1.67)	3 fewer per 1,000 (from 13 fewer to 17 more)	⊕⊕⊕◯ Moderate
Nasal trauma/ important	6	Not serious	Not serious	Not serious	Serious b	42/578 (7.3%)	85/601 (14.1%)	RR 0.52 (0.37 to 0.74)	68 fewer per 1,000 (from 37 fewer to 89 fewer)	⊕⊕⊕◯ Moderate

Analysis

Heated Humidified High-Flow Nasal Cannula for Preterm Infants: An Updated Systematic Review and Meta-analysis

Nigel Fleeman[1], Yenal Dundar[1,2], Prakesh S Shah[3] and Ben NJ Shaw[4]

International Journal of Technology Assessment in Health Care

Primary support

Study	Study design, location	HHHFNC flow rate	Arm (number of preterm infants)	Eligibility criteria	GA, mean (*SD*), weeks	Birth weight, mean (*SD*) g
Nair and Karna 2005(31)	Single center: United States	1.8 L/min	HHHNFC ($n = 13$)[a] NCPAP ($n = 15$)[a]	GA 27 to 34 weeks	32 (0.5) 31 (0.5)	1,675 (139) 1,493 (64)
Iranpour et al 2011(19)	Single center: Iran	1.5 L/min to 3 L/min	HHHFNC ($n = 35$) NCPAP ($n = 35$)	GA 30 to 35 weeks	32.3 (1.6) 33.0 (1.9)	1,824 (410) 2,021 (498)
Yoder et al 2013 (37)	Multicenter: United States	3 L/min to 8 L/min	HHHNFC ($n = 58$) NCPAP ($n = 67$)	No limitation on GA[b]	NR[b] NR[b]	NR[b] NR[b]
Klingenberg et al 2014(23)	Single center, cross over: Norway	5 L/min to 6 L/min	HHHNFC / NCPAP ($n = 20$)[c]	GA <34 weeks	29.3 (1.7)[c]	1,234 (353)[c]
Kugelman et al 2014(24)	Single center: Israel	1 L/min to 5 L/min	HHHFNC ($n = 38$) NIPPV ($n = 38$)	GA <35 weeks	31.8 (2.3) 32.0 (2.3)	1,759 (488) 1,835 (530)
Glackin et al 2016(18)	Single center: Ireland	7 L/min	HHHNFC ($n = 22$) NCPAP ($n = 22$)	GA <30 weeks	26.9 (1.5) 27.3 (1.5)	868 (160) 891 (202)
Lavizzari et al 2016(25)	Single center non-inferiority: Italy	4 L/min to 6 L/min	HHHNFC ($n = 158$) NCPAP ($n = 158$)	GA (29 weeks to 36 weeks	33.1 (1.9) 33.0 (2.1)	1,968 (581) 1,908 (528)
Roberts et al 2016(33)	Multicenter non-inferiority: Australia and Norway	6 L/min to 8 L/min	HHHNFC ($n = 278$) NCPAP ($n = 286$)	GA ≥28 weeks	32.0 (2.1) 32.0 (2.2)	1,737 (580) 1,751 (599)
Shin et al 2017 (35)	Single center non-inferiority: South Korea	3 L/min to 7 L/min	HHHNFC ($n = 42$) NCPAP ($n = 43$)	GA >30 to <35 weeks	32.5 (1.5) 33.0 (1.2)	2,058 (371) 1,996 (374)
Murki et al 2018 (38)	Two centernon-inferiority: India	5 L/min to 7 L/min	HHHNFC ($n = 133$) NCPAP ($n = 139$)	≥28 weeks	31.8 (1.9) 31.6 (2.2)	1,632 (431) 1,642 (437)

Support

Nasal High-Flow Therapy for Primary Respiratory Support in Preterm Infants

Calum T. Roberts, M.B., Ch.B., Louise S. Owen, M.D., Brett J. Manley, Ph.D

N ENGL J MED 375;12 NEJM.ORG SEPTEMBER 22, 2016

HIPSTER Trial: 9 NICUs (Australia+Norway) 5/2013 – 6/2015

ICs and Random: GW ≥ 28+0, CPAP after delivery < 24hrs, no ventilation, no surfaktant
⇒ 1. CPAP 6cmH20, 2. HFNC 6l/min (CPAP after failure)

Failure criteria: **1. FiO2 ≥ 0.4** (>1hr) 2. **pH < 7.2 /pCO2 > 60mmHg** (>1hr) 3. **Apnea >2 with PPV/24h or 6 episodes with any intervention**

Primary Outcome

Per-protocol analysis	High-Flow Group (N=278)	CPAP Group (N=286)	Risk Difference (95% CI)*	P Value
Treatment failure within 72 hr	64/264 (24.2)	36/279 (12.9)	11.3 (4.8 to 17.8)	<0.001
Intubation within 72 hr	39/264 (14.8)	33/279 (11.8)	2.9 (−2.8 to 8.7)	0.31
Primary intention-to-treat analysis				
Gestational age <32 wk	30/140 (21.4)	24/149 (16.1)	5.3 (−3.7 to 14.3)	0.25
Gestational age ≥32 wk	13/138 (9.4)	9/137 (6.6)	2.9 (−3.5 to 9.3)	0.38

Respiratory

HIPSTER Trial: 9 NICUs (Australia+Norway) 5/2013 – 6/2015

Event	High-Flow Group (N=278)	CPAP Group (N=286)	Risk Difference (95% CI)*	P Value
	no. of infants (%)		*percentage points*	
Death before discharge	1 (0.4)	1 (0.4)	0.0 (−1.0 to 1.0)	0.98
Oxygen supplementation, respiratory support, or both at postmenstrual age of 36 wk†	17 (12.1)	17 (11.4)	0.7 (−6.7 to 8.2)	0.85
Pneumothorax or other air leak syndrome				
During assigned treatment	0	6 (2.1)	−2.1 (−3.8 to −0.4)	0.02
Any time during admission	10 (3.6)	8 (2.8)	0.8 (−2.1 to 3.7)	0.59
Postnatal glucocorticoid treatment for lung disease	1 (0.4)	3 (1.0)	−0.7 (−2.1 to 0.7)	0.33
Nasal trauma	23 (8.3)	53 (18.5)	−10.3 (−15.8 to −4.7)	<0.001
Patent ductus arteriosus treated with medication or surgical ligation	11 (4.0)	6 (2.1)	1.9 (−1.0 to 4.7)	0.20
Confirmed sepsis‡	7 (2.5)	13 (4.5)	−2.0 (−5.1 to 1.0)	0.19
Necrotizing enterocolitis, Bell's stage II or III§	2 (0.7)	0	0.7 (−0.3 to 1.7)	0.15
Isolated intestinal perforation	0	1 (0.3)	−0.3 (−1.0 to 0.3)	0.32
Laser surgery for retinopathy of prematurity†	0	1 (0.7)	−0.7 (−2.0 to 0.6)	0.33
Intraventricular hemorrhage, grade 3 or 4†	4 (2.9)	1 (0.7)	2.2 (−0.9 to 5.2)	0.15
Cystic periventricular leukomalacia†	3 (2.1)	2 (1.3)	0.8 (−2.2 to 3.8)	0.60

NICU

Nasal High-Flow Therapy for Newborn Infants in Special Care Nurseries

N ENGL J MED 380;21 NEJM.ORG MAY 23, 2019

Brett J. Manley, Ph.D., Gaston R.B. Arnolda, Ph.D., Ian M.R. Wright, M.B., B.S.

HUNTER Trial: 9 non-tertiary centers, 4/2015 – 11/2017

IC and Random: GW ≥ 31+0, BW ≥ 1200g; CPAP after delivery < 2hrs ⇒ 1. CPAP 6cmH20, 2. HFNC 6l/min

Failure criteria: **1. FiO2 ≥ 0.4** (>1hr) 2. **pH < 7.2 /pCO2 > 60mmHg** (2 samples) 3. **Apnea >2 with PPV/24h or 6 episodes with any intervention**

RESULTS

Primary Outcome Per-protocol analysis	All Patients	High-Flow Group (N=381)	CPAP Group (N=373)	Univariate Analysis	Adjusted Analysis‡
Treatment failure within 72 hr after randomization	677	49/339 (14.5)	27/338 (8.0)	6.5 (1.7 to 11.2)	5.5 (0.5 to 10.4)
Gestational age <34 wk	129	14/65 (21.5)	10/64 (15.6)	5.9 (–7.5 to 19.3)	6.0 (–8.0 to 19.9)
Gestational age ≥34 wk	548	35/274 (12.8)	17/274 (6.2)	6.6 (1.7 to 11.5)	5.5 (0.2 to 10.7)

Adjusted for: GW, BW, AN steroids, sex

Therapy

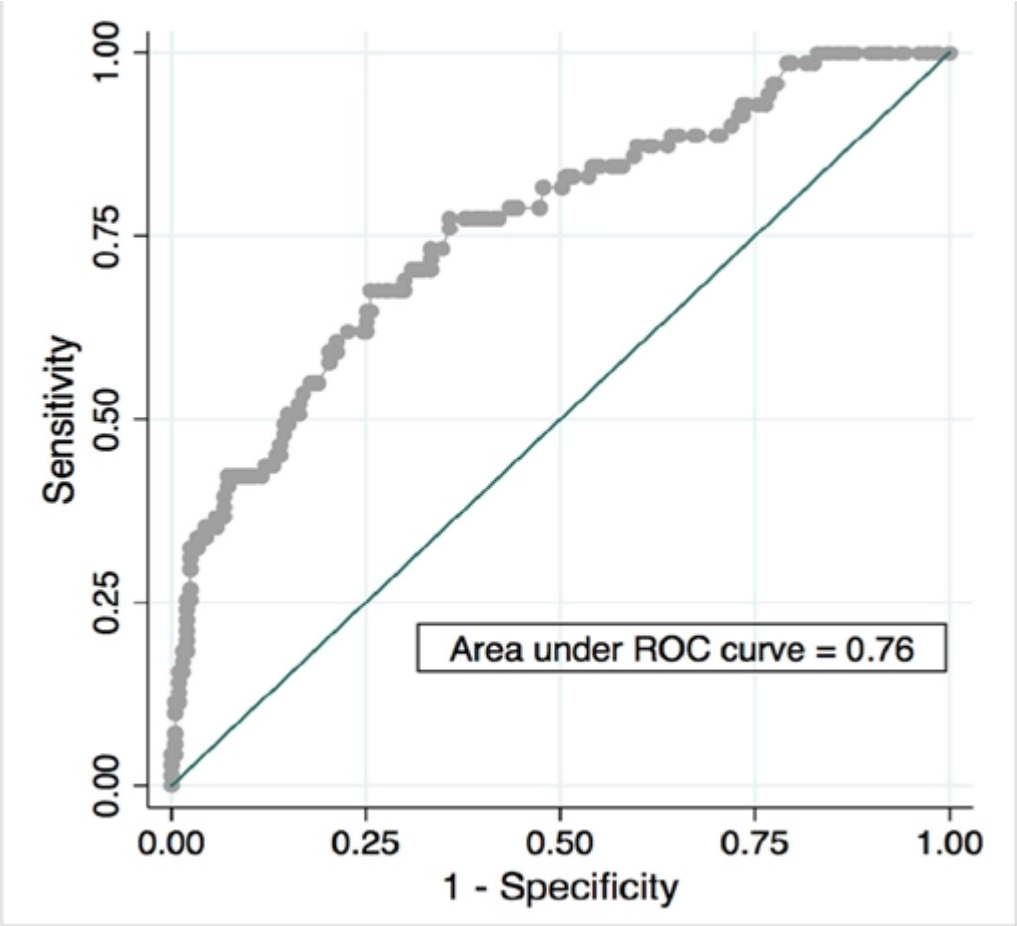
HUNTER Trial: 9 non-tertiary centers, 4/2015 – 11/2017

N ENGL J MED 380;21 NEJM.ORG MAY 23, 2019

Secondary Outcomes and Adverse Events.	High-Flow Group (N=381)	≈	CPAP Group (N=373)	
Mechanical ventilation through an endotracheal tube — no. (%)				
<72 hr after randomization	21 (5.5)		22 (5.9)	–0.4 (–3.7 to 2.9)
At any time after randomization	25 (6.6)		22 (5.9)	0.7 (–2.8 to 4.1)
Supplemental oxygen or respiratory support		≈		
At 28 days of life; born ≥32 wk gestational age‡‡	2 (0.5)		0	0.5 (–0.2 to 1.3)
At 36 wk postmenstrual age; born <32 wk gestational age§§	0		0	NC
Drained with needle thoracocentesis or intercostal catheter**	9 (2.4)		18 (4.8)	–2.5 (–5.1 to 0.2)
Nasal trauma after randomization	2 (0.5)		6 (1.6)	–1.1 (–2.6 to 0.4)

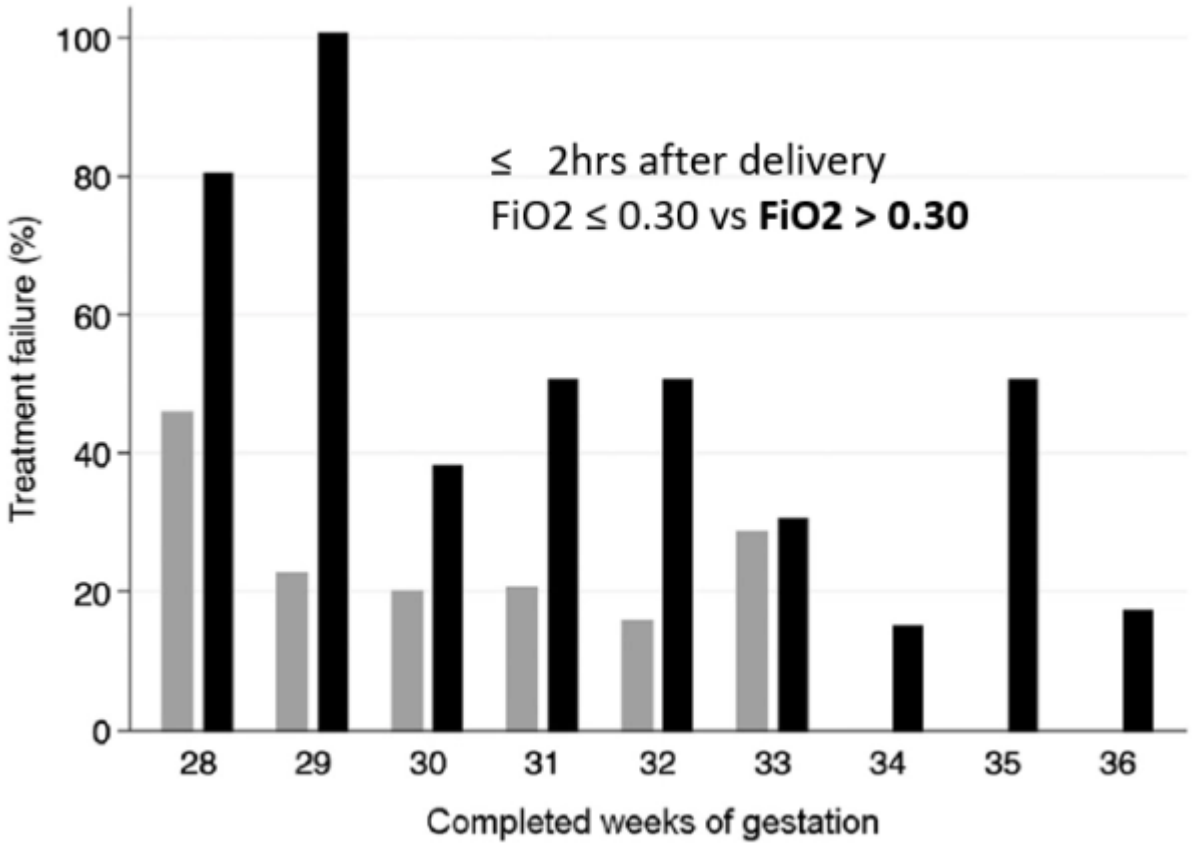
Study

គំរូ ROC រួមមាន A និង FiO2 ចែដន្យជាមុន



FiO2

ការបរាជ័យ HFNC អាស្រ័យលើការចែដន្យ FiO2 ជាមុន



FiO2

Refining the Use of Nasal High-Flow Therapy as Primary Respiratory Support for Preterm Infants

Brett J. Manley, PhD[1,2,3], Calum T. Roberts, MB, ChB[1,2,4,5], Dag H. Frøisland, PhD[1,6], Lex W. Doyle, MD[2,3,7], Peter G. Davis, MD[1,2,3], and Louise S. Owen, MD[1,2,3]

Results There were 278 preterm infants included, with a mean gestational age (GA) of 32.0 ± 2.1 weeks and a birth weight of 1737 ± 580 g; of these, nHF treatment failed in 71 infants (25.5%). Treatment failure was moderately predicted by a lower GA and higher prerandomization fraction of inspired oxygen (FiO_2): area under a receiver operating characteristic curve of 0.76 (95% CI, 0.70-0.83). Nasal HF treatment success was more likely in infants born at ≥30 weeks GA and with prerandomization FiO_2 <0.30.

Conclusions In preterm infants ≥28 weeks' GA enrolled in a randomized, controlled trial, lower GA and higher FiO_2 before randomization predicted early nHF treatment failure. Infants were more likely to be successfully treated with nHF from soon after birth if they were born at ≥30 weeks GA and had a prerandomization FiO_2 <0.30. However, even in this select population, continuous positive airway pressure remains superior to nHF as early respiratory support in preventing treatment failure. *(J Pediatr 2018;196:65-70).*

30/30 rule

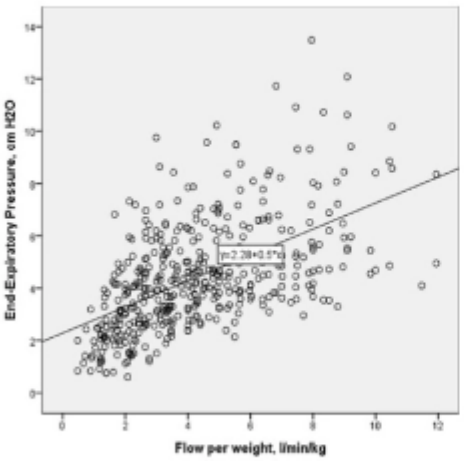
Further research into how to best select which infants receiving noninvasive respiratory support should receive surfactant treatment is required.

30 rule is applied. Further prospective, RCTs are required to optimize the use of nHF as primary respiratory support for preterm infants. ■

Therapy

អថេរដែលមានផលប៉ះពាល់យ៉ាងសំខាន់លើ pharyngeal EEP

លំហូរ r= 0.589



សាមញ្ញ និងសុវត្ថិភាព

ទីតាំងមាត់ r= 0.589
ភាពខុសគ្នា 0.6-2.3cmH2O

ទម្ងន់ r= -0,247 p< 0.001
Δ 0.7 cmH2O/kg

សមាមាត្រទៅនឹងណារែស r= 0,165 p< 0.001
0.7< and > 0.7

pEEP ព្យាករណ៍ = -6.4+0.53 x (-FLOW) +1.45 x (មាត់ទីតាំង 0/1) – 1.86 x (WEIGHT) + 0.31 x (GW wks)

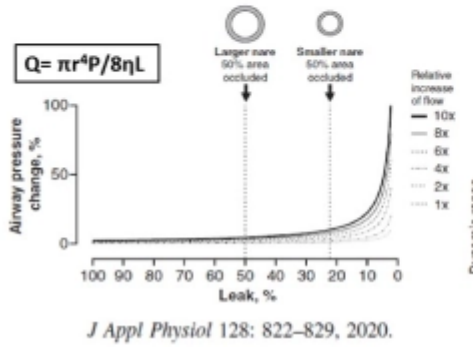
EEP

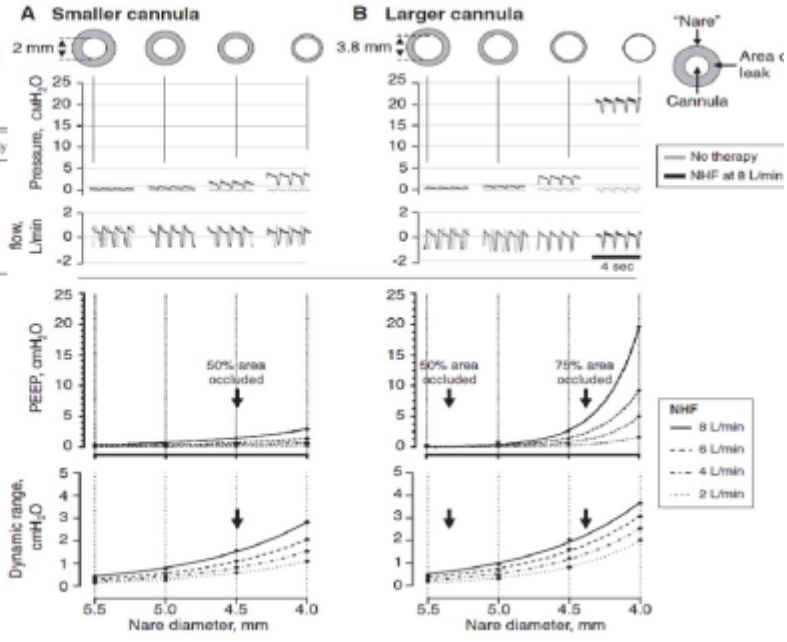
Mechanisms of nasal high flow

Table 1. *Anthropometric data*

	Pressure Study	Ventilation Study
n	9	20
Gestation, wk	37.1 ± 1.4	39.1 ± 1.5
Postnatal age, day	1.1 ± 0.4	1.3 ± 0.5
Birth weight, g	2,573 ± 477	3,090 ± 441
Length, cm	48.4 ± 2.2	50.5 ± 2.1
Male, *n* (%)	5 (56%)	12 (60%)

Data are means ± SD.





J Appl Physiol 128: 822–829, 2020.

Mechanisms

Available online at www.sciencedirect.com

Resuscitation

journal homepage: www.elsevier.com/locate/resuscitation

Neonatal Life Support 2020 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations☆

PEEP Versus No PEEP

Oxygen for Preterm Resuscitation

Treatment Recommendations

We suggest using PEEP for the initial ventilation of premature newborn infants during delivery room resuscitation (weak recommendation, low-quality evidence).

We suggest the range of 21% to 30% oxygen because all trials used this for the low oxygen concentration group. Subsequent titration of oxygen concentration using pulse oximetry is advised (weak recommendation, very low-certainty evidence).

PEEP

Stabilisation of premature infants in the delivery room with nasal high flow

Peter Reynolds, Stamatina Leontiadi, Tracy Lawson, Tosin Otunla, Olayinka Ejiwumi, Nicola Holland

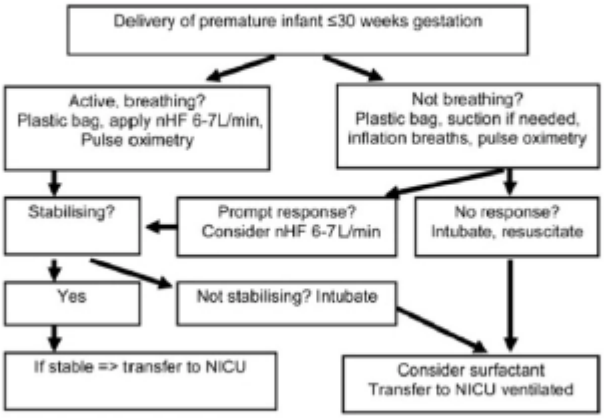


Figure 2 Protocol for stabilisation. nHF, nasal high flow; NICU, neonatal intensive care unit.

Reynolds P, *et al. Arch Dis Child Fetal Neonatal Ed* 2016;**101**:F284–F287

Stabilisation

Stabilisation of premature infants in the delivery room with nasal high flow

Peter Reynolds, Stamatina Leontiadi, Tracy Lawson, Tosin Otunla, Olayinka Ejiwumi, Nicola Holland

Ethics Committee (REC). Written parental consent was obtained prior to delivery. The study was terminated after 28 babies had been enrolled in agreement with the R and D department and the REC as feasibility with successful completion of protocol in all cases had been established.

Table 1 Characteristics of study participants (n=28)

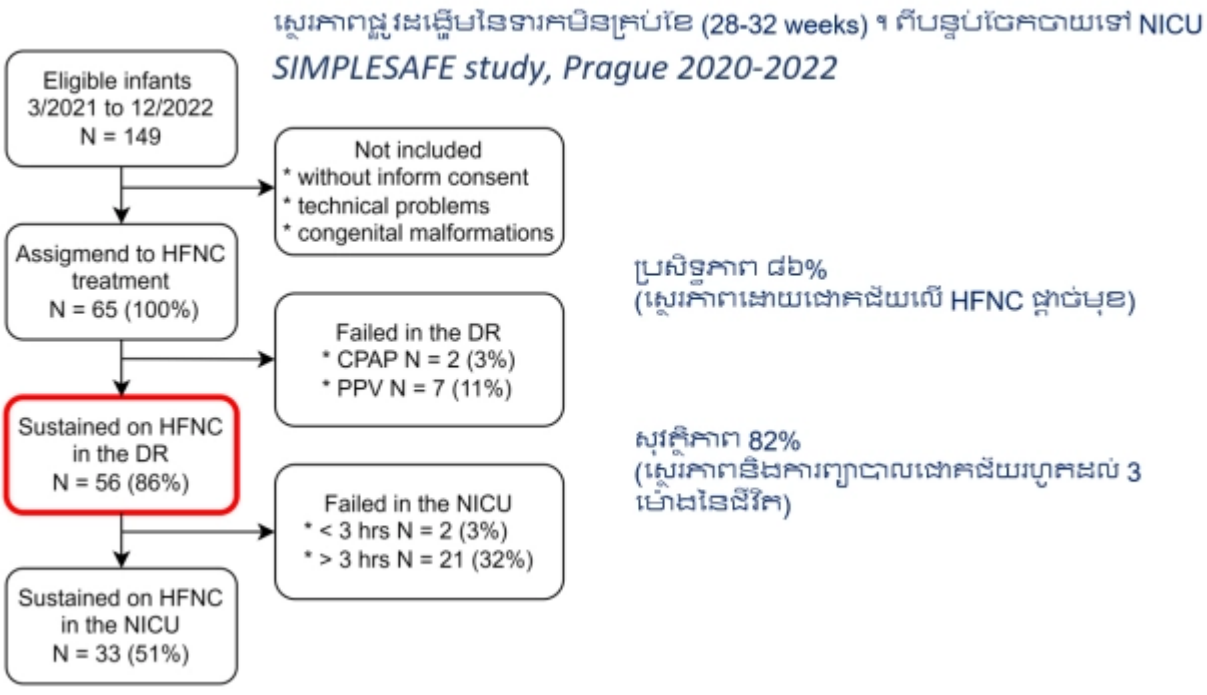
GA at delivery	N (% total)	Vaginal/caesarean delivery	PPROM >24 h (%)	Intubated for transfer to NICU	Surfactant in DR
23+0 to 23+6	1 (4)	1/0	0 (0)	1	1
24+0 to 24+6	3 (11)	2/1	1 (33)	2	2
25+0 to 25+6	6 (18.5)	2/4	0 (0)	0	1
26+0 to 26+6	5 (18.5)	2/3	2 (40)	0	0
27+0 to 27+6	5 (18.5)	2/3	0 (0)	0	0
28+0 to 28+6	5 (18.5)	1/4	1 (20)	0	0
29+0 to 29+6	3 (11)	1/2	1 (33)	0	0
Mean GA 26+5	28 (100)	11 (39%)/17 (61%)	5 (18)	3 (11%)	4 (14%)

DR, delivery room; GA, gestational age; NICU, neonatal intensive care unit; PPROM, preterm prelabour rupture of membranes.

Reynolds P, *et al. Arch Dis Child Fetal Neonatal Ed* 2016;**101**:F284–F287

Stabilisation

- ការដឹកជញ្ជូន VT ខ្ពស់ក្នុងអំឡុងពេលរបាំង PPV នៅពេលកើតត្រូវបានផ្សារភ្ជាប់ជាមួយនឹងការរងរបួសខួរក្បាល។ យុទ្ធសាស្ត្រកំណត់ការចែកចាយ VT ក្នុងអំឡុងពេលរបាំង PPV គួរតែត្រូវបានប្រើដើម្បីការពារការដឹកជញ្ជូន VT ខ្ពស់។ (Quaasim M 2019)



Study

សេចក្តីសង្ខេប៖ HFNC 2-8l / នាទី។

- ការប្រើប្រាស់គ្លីនិកនៃ HFNC កំពុងកើនឡើង។
- HFNC អាចត្រូវបានប្រើជាជំនួយផ្លូវដង្ហើមចម្បងរបស់ទារកមិនគ្រប់ខែ≥ 28 សប្តាហ៍ដែលទទួលរងពី RDS កម្រិតស្រាល-មធ្យម។
- ច្បាប់ 30/30 អាចកាត់បន្ថយការបរាជ័យ HFNC ។
- ប្រភេទ Crossover ទៅ CPAP មុនគឺល្អជាងពេលក្រោយ (FiO2 > 0.35, លំហូរ 8l)
- HFNC ហាក់ដូចជាមានសុវត្ថិភាព និងមានប្រសិទ្ធភាពក្នុងការជួយផ្លូវដង្ហើម សូម្បីតែនៅក្នុងបន្ទប់សម្រាលក៏ដោយ ក៏តម្រូវឱ្យមានការស៊ើបអង្កេតបន្ថែម។