CARE OF PRETERM & LBW BABIES
Preterm: < 37 weeks

Term: ≥ 37 weeks

Late Preterm (LPT): 34-36 6/7 weeks

BEFORE YOU ARE BORN

Fetal Growth From 8 to 40 Weeks

Embryo at 8 Weeks 16
Fetus at 12 Weeks 20
24
28
32
36
40

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DEFINITIONS

In 1948, first World Health Assembly defined babies with B wt. <2500gms or <37 wks as immature.

In 1950, WHO revised preterm infants as < 37wks which was endorsed by AAP & ACOG.

Common preterm sub groups include:
• Extremely preterm <28wks
• Very preterm <32wks
• Moderately preterm <32-36wks

In July 2005, NICHD of NIH recommended birth between 34 completed wks (34⁰/⁷) and less than 37 completed wks (36⁶/⁷) as Late preterm.

34th wk marks as obstetrical mile after which antenatal steroids not administered.

Means indeed premature, not almost term, as the near term phrase might convey.

Late preterm vs Near term
India’s contribution to global neonatal deaths

Causes of neonatal mortality

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## FETAL GROWTH

<table>
<thead>
<tr>
<th>GESTATION</th>
<th>NATURE OF GROWTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 20 wks</td>
<td>Stage of Hyperplasia</td>
</tr>
<tr>
<td>20 - 28 wks</td>
<td>Stage of Hyperplasia &amp; Hypertrophy</td>
</tr>
<tr>
<td>28wks - Term</td>
<td>Stage of Hypertrophy</td>
</tr>
</tbody>
</table>

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BIRTH WEIGHT

There is no indicator in human history which tells us as much about the past events and the future trajectory of life as the weight of the baby at birth.”
FETAL GROWTH VARIATION - TERMINOLOGY

• Birth Weight
  - First Wt. Record of product of conception
    Preferably in 1 hr. of Life
  - Can be measured upto 24hrs.
    Normal > 2500gms.

• Low Birth Weight (LBW)
  - B.Wt. < 2500Gms

• Very Low Birth Weight (VLBW)
  - B.Wt. <1500Gms

• Extremely Low Birth Weight (ELBW)
  - B.Wt. <1000Gms

• IUGR - Rate of Fetal Growth less than normal for the population & for growth potential of the specific infant
  - Symmetric
    - Both Brain & Body Growth
  - Asymmetric
    - Brain Spared Growth
BORN PRETERM & LBW

• Leading cause of neonatal mortality (75% NMR, 40% IMR)
• Incidence 28-30%, compared to 5% in Japan & 7% in U.S.A.
• Incidence of prematurity in India 12.8%
• -Incidence of long term disability (3-4 FOLD-)
• AT RISK - FOR POOR CHILD SURVIVAL

• HENCE PREVENTION OF LBW SHOULD BE ONE OF THE NATION’S TOP PRIORITIES.
# Percentage Distribution of Deaths and Causes Peculiar to Neonate

<table>
<thead>
<tr>
<th>S.No</th>
<th>Specific cause group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prematurity</td>
<td>46.4</td>
</tr>
<tr>
<td>2</td>
<td>Respiratory distress &amp; Infection of Newborn</td>
<td>14.4</td>
</tr>
<tr>
<td>3</td>
<td>Diarrhoea of Newborn</td>
<td>8.0</td>
</tr>
<tr>
<td>4</td>
<td>Congenital Malformation</td>
<td>4.6</td>
</tr>
<tr>
<td>5</td>
<td>Cord Infection including Tetanus</td>
<td>4.5</td>
</tr>
<tr>
<td>6</td>
<td>Birth Injury</td>
<td>3.0</td>
</tr>
<tr>
<td>7</td>
<td>Not Classifiable</td>
<td>19.1</td>
</tr>
</tbody>
</table>
CHARACTERISTICS AND EXAMPLES OF IUGR

**SYMmetric**
- Early onset
- Constitutional or “normal” small
- Low profile BPD
- ↓ Growth Potential
- Normal PI
- Low risk for perinatal asphyxia
- Brain symmetry to body size
- Normal blood flow in ICA
- Low risk for hypoglycemia

**EXAmPLES**
- Genetic
- TORCH
- Chromosomal
- Anomalad syndromes

**ASYMMetric**
- Late onset
- Environmental
- Late flattening BPD
- Growth arrest
- Low PI
- -Risk of perinatal asphyxia
- Brain sparing
- Redistribution of blood in ICA
- Risk of hypoglycemia

**EXAmPLES**
- Chronic Fetal distress(hypoxia)
- Pre-eclampsia
- Chronic Hypertension
- Poor calorie intake
- Diabetes-class D to F
### FACTORS DETERMINING VARIANCE IN BIRTH WEIGHT

<table>
<thead>
<tr>
<th>PERCENT OF TOTAL VARIANCE</th>
<th>(I) FETAL</th>
<th>(II) MATERNAL</th>
<th>(III) UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genotype</td>
<td>16</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Sex</td>
<td>2</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>52</td>
<td>52</td>
</tr>
<tr>
<td>Mat. Environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mat Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chromically malnourished pregnant woman

Delivers low birth weight Newborn

Malnutrition and infections in infancy and adolescence

Stunted adult

Reduced work output, impaired learning ability

Poverty

Chronic malnutrition
OVERVIEW OF RISK FACTORS FOR LOW BIRTH WEIGHT

I) DEMOGRAPHIC
- Race (Black)
- Present Low Socio-economic status
- Socio-economic status of infants’ grandparents

II) PREPREGNANCY
- Low Birth Weight for height
- Short stature
- Chronic Medical illness
- Poor nutrition
- Low mat.height at mother’s birth
- Previous LBW baby
- Uterine & Cervical anomalies
- Parity (none or >5)

III) PREGNANCY
- Multiple Gestation
- Birth Order
- Anemia
- Fetal disease
- Pre-eclampsia & Hypertension
- Infections
- Placental problems
- PROM

IV) BEHAVIOURAL
- Low Educational status
- Smoking
- No care or inadequate prenatal care
- Poor Weight gain
- Alcohol abuse
- Unmarried
- Illicit- Prescription drugs
- Stress (Physical & Psychologic)
CLINICAL PROBLEMS OF LOW BIRTH WEIGHT

• Preterm & growth restricted infants have independent and overlapping clinical problems.

• Consequence of small size for gestational age depend on the aetiology, severity & duration of growth restriction.

• Perinatal mortality rate among IUGR babies is 5-20 times>than among appropriately grown infants.
## INTRAUTERINE DEATH

<table>
<thead>
<tr>
<th>Pathology/Pathophysiology</th>
<th>Prevention/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic hypoxia</td>
<td>Antenatal Surveillance</td>
</tr>
<tr>
<td>Placental insufficiency</td>
<td>Fetal growth by USG</td>
</tr>
<tr>
<td>Growth Failure</td>
<td>Biophysical profile</td>
</tr>
<tr>
<td>Malformation</td>
<td>Doppler velocimetry</td>
</tr>
<tr>
<td>Infection</td>
<td>Maternal treatment: Bed</td>
</tr>
<tr>
<td>Rest, ?O\textsubscript{2}</td>
<td></td>
</tr>
<tr>
<td>Infarction/abruption</td>
<td>Delivery for</td>
</tr>
<tr>
<td>severe/worsening</td>
<td>fetal distress</td>
</tr>
</tbody>
</table>

SGA status - independent predictor of increased fetal, perinatal and neonatal death
**ASPHYXIA**

<table>
<thead>
<tr>
<th>Pathology/Pathophysiology</th>
<th>Prevention/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute hypoxia/abruption</td>
<td>Antepartum/Intrapartum monitoring</td>
</tr>
<tr>
<td>Chronic hypoxia</td>
<td></td>
</tr>
<tr>
<td>Placental insufficiency/</td>
<td>Adequate Neonatal resuscitation</td>
</tr>
<tr>
<td>Pre-eclampsia</td>
<td></td>
</tr>
<tr>
<td>AcidosiS</td>
<td></td>
</tr>
<tr>
<td>Glycogen depletion</td>
<td></td>
</tr>
</tbody>
</table>

* Poorly tolerate labor and vaginal delivery & signs of fetal distress very common

*Sequelae include multiple organ dysfunction - HIE, MAS, GIT hypoperistalsis, ATN etc.,
NEONATAL RESUSCITATION PROGRAMME

2005

2010

NEONATEAL RESUSCITATION ALGORITHM

Birth

Yes, stay with mother

Routine Care:
- Provide warmth
- Assure open airway
- Dry
- Ongoing evaluation

No

Term Gestation? Breathing or Crying? Good tone

Yes

No

HR below 100, Gasping or Apnoea

Yes

No

Labouring Breathing Persistent Cyanosis

Yes

No

PPV, Consider SpO2 monitoring

Post-resuscitation Care

Yes

No

Consider SpO2 monitoring, Consider CPAP

Post-resuscitation Care

Yes

No

Ensure adequate ventilation
Consider ET intubation

Post-resuscitation Care

Yes

No

Chest compression Coordinate with PPV

Post-resuscitation Care

Yes

No

HR below 60?

Post-resuscitation Care

Yes

No

IV Epinephrine

BAPUJI CHILD HEALTH INSTITUTE & RESEARCH CENTRE, DAVANGERE-577004

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INVERTED PYRAMID APPROACH FOR NEONATAL RESUSCITATION
TEN STEPS

Being prepared for Resuscitation
- Prevention of Heat loss
- Positioning of the baby
- Suctioning of Airways
- Tactile stimulation
- Free flow O₂ Administration
- Bag & Mask ventilation
- Chest Compression
- Endotracheal Intubation
- Medication

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RESUSCITATION CORNER IN DELIVERY ROOM
INITIAL STEPS OF RESUSCITATION
BAG & MASK VENTILATION (BMV)
NEONATAL INTENSIVE CARE UNIT
# HYALINE MEMBRANE DISEASE (HMD)

<table>
<thead>
<tr>
<th>Pathogenesis/Pathophysiology</th>
<th>Prevention/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Prematurity</td>
<td>Prevention of Prematurity</td>
</tr>
<tr>
<td>*Asphyxia</td>
<td>Antenatal steroids Dm/Bm</td>
</tr>
<tr>
<td>*Hypothermia</td>
<td>Prevention of asphyxia</td>
</tr>
<tr>
<td>*Hypoxia</td>
<td>Intubation &amp; Surfactant administration</td>
</tr>
<tr>
<td>*Acidosis</td>
<td></td>
</tr>
<tr>
<td>*Multiple gestation</td>
<td></td>
</tr>
<tr>
<td>Diffuse surfactant deficiency</td>
<td></td>
</tr>
</tbody>
</table>

**Prevention**

- - Prevention of Prematurity
- - Antenatal steroids Dm/Bm
- - Prevention of asphyxia
- - Intubation & Surfactant administration

**Treatment**

~ Maintain
   - Euthemia/Normoxemia
~ Augmented O₂/IMV
~ Surfactant administration

HMD not increased in more mature SGA infants
HMD IN A PRETERM BABY

Ground glass appearance of lungs
PNEMOTHORAX & PNEMOPERICARDIUM IN A VENTILATED HMD BABY
# MECONIUM ASPIRATION SYNDROME (MAS)

<table>
<thead>
<tr>
<th>Pathogenesis/Pathophysiology</th>
<th>Prevention/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Hypoxemia</td>
<td>- Intrapartum suctioning by obstetrician</td>
</tr>
<tr>
<td>*Placental Insufficiency</td>
<td>- Resuscitation including tracheal suctioning for definite, severe aspiration</td>
</tr>
<tr>
<td></td>
<td>- Warmth/Augmented $O_2$/IMV &amp; good supportive care in NICU</td>
</tr>
<tr>
<td>*Meticulous ante &amp; Intrapartum fetal monitoring</td>
<td></td>
</tr>
<tr>
<td>*CS when indicated</td>
<td></td>
</tr>
<tr>
<td>*Saline lavage, steroids, chest physiotherapy &amp; antibiotics have no role in prevention of MAS</td>
<td></td>
</tr>
</tbody>
</table>
MECONIUM ASPIRATION SYNDROME (MAS)

Fluffy shadows & bilateral infiltrates
RISK FACTORS FOR THERMAL INSTABILITY IN PRETERM

COLD STRESS

- SA (Flexion posture)
- Convection & Radiation Heat Loss

Stimulates
Skin Thermoreceptors
Sympathetic Nn Reflex

- Ventilation
- PaCO₂

Catecholamines

Lipolysis

Heat Loss

Vasoconstriction

Heat Loss

Heat Production

HEAT BALANCE

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## HYPOTHERMIA

### Pathogenesis/Pathophysiology

<table>
<thead>
<tr>
<th>Cold stress</th>
<th>Prevention/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoxia</td>
<td>Protect from increased heat loss</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>- Dry infant</td>
</tr>
<tr>
<td>↓ fat stores</td>
<td>- Radiant warmer</td>
</tr>
<tr>
<td>↓ subcutaneous insulation</td>
<td>- Hat</td>
</tr>
<tr>
<td>↑ surface area</td>
<td>- Thermneutral environment</td>
</tr>
<tr>
<td>Catecholamine depletion</td>
<td><strong>Treatment</strong></td>
</tr>
<tr>
<td></td>
<td>- Rewarming</td>
</tr>
<tr>
<td></td>
<td>- Correct hypoglycemia</td>
</tr>
<tr>
<td></td>
<td>- Correct acidosis</td>
</tr>
<tr>
<td></td>
<td>- Nutritional support</td>
</tr>
</tbody>
</table>

*Selective brain cooling of Neonates suffering perinatal HIE may prove to be of advantage for IUGR infants as well*
KANGAROO CARE

• Skin to Skin care – Kangaroo care is promoted for nurturing infants-who are held naked between mothers breast, as if in a Kangaroo’s pouch.

• RCT’s have shown enhanced mother-infant attachment
  • Greater maternal self esteem
  • Prolonged & enhanced lactation
  • Increased infant alertness
  • Better weight gain

• Behavioral studies have demonstrated
  • More homogenous sleep patterns
  • Less irritability in later infancy
  • More direct social eye contact
# HYPOGLYCEMIA

<table>
<thead>
<tr>
<th>Pathogenesis/Pathophysiology</th>
<th>Prevention/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>↓ Hepatic/Muscle glycogen</td>
<td>Frequency measurement of blood glucose</td>
</tr>
<tr>
<td>↓ Alternative energy source</td>
<td>-0,2,6,12,18,24,36,48,60,72 hrs........</td>
</tr>
<tr>
<td>Heat Loss</td>
<td>Treatment</td>
</tr>
<tr>
<td>Hypoxia</td>
<td>- Early IV fluid initiation-10% Dex</td>
</tr>
<tr>
<td>↓ Gluconeogenesis</td>
<td>- Enteral nutrition</td>
</tr>
<tr>
<td>↓ Counter-regulatory hormones</td>
<td>- Warmth/Normoxemia</td>
</tr>
<tr>
<td>↑ Insulin Sensitivity</td>
<td>- Rarely steroids/Glucagon/Diazoxide</td>
</tr>
</tbody>
</table>

*Avoid repeated “minibolus”

*Untreated Hypoglycemia contribute to poor neurodevelopmental outcome
# HYPERGLYCEMIA

<table>
<thead>
<tr>
<th>Pathogenesis/Pathophysiology</th>
<th>Prevention/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common in VLBW/ELBW</td>
<td>Glucose monitoring</td>
</tr>
<tr>
<td>Low insulin secretion rate</td>
<td>Glucose &lt; 10mgs/min/kg</td>
</tr>
<tr>
<td>↑Catecholamine &amp; Glucogen effects</td>
<td>Insulin administration</td>
</tr>
<tr>
<td>Aminophylline Rx</td>
<td></td>
</tr>
</tbody>
</table>
FEEDING CORNER IN NICU
ROOMING-IN & BEDDING-IN
<table>
<thead>
<tr>
<th><strong>Pathogenesis/Pathophysiology</strong></th>
<th><strong>Prevention/Treatment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>More frequent in IUGR/SGA</td>
<td>*Monitor Hct. In first 72 hrs</td>
</tr>
<tr>
<td>Chronic Hypoxia</td>
<td>*Glucose and O2 administration</td>
</tr>
<tr>
<td>Maternal fetal transfusion</td>
<td>Treatment</td>
</tr>
<tr>
<td>↑Erythropoiesis</td>
<td>(a) Hct 65-70% - Relax IV fluids</td>
</tr>
<tr>
<td></td>
<td>asymptomatic</td>
</tr>
<tr>
<td></td>
<td>(b) Hct 65-70% - Partial exchange</td>
</tr>
<tr>
<td></td>
<td>symptomatic</td>
</tr>
<tr>
<td></td>
<td>(c) Hct &gt;70% - Partial exchange</td>
</tr>
</tbody>
</table>

*Leads to abnormal cardiopulmonary & Metabolic postnatal adaptation

*Partial exchange reduces blood viscosity & improves tissue perfusion
<table>
<thead>
<tr>
<th>Pathogenesis/Pathophysiology</th>
<th>Prevention/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor physical barrier - skin &amp; MM</td>
<td>Prevention</td>
</tr>
<tr>
<td>Sub-optimal chemotaxis/Phagocytosis</td>
<td></td>
</tr>
<tr>
<td>Hypocomplimentemia</td>
<td>Prevention</td>
</tr>
<tr>
<td>Lower immunoglobulin levels</td>
<td></td>
</tr>
<tr>
<td>Invasive procedures-Intubation/IV access</td>
<td>Prevention</td>
</tr>
<tr>
<td>Malnutrition</td>
<td></td>
</tr>
<tr>
<td>Congenital infection</td>
<td>Treatment</td>
</tr>
<tr>
<td></td>
<td>* Strict hand washing</td>
</tr>
<tr>
<td></td>
<td>* Umbilical cord care</td>
</tr>
<tr>
<td></td>
<td>* Aseptic precautions during procedures</td>
</tr>
<tr>
<td></td>
<td>* NICU Inf. surveillance</td>
</tr>
<tr>
<td></td>
<td>* Breastfeeding</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td></td>
<td>* IV - Antibiotics</td>
</tr>
<tr>
<td></td>
<td>* Supportive treatment</td>
</tr>
<tr>
<td></td>
<td>* IV-Immunoglobulin</td>
</tr>
<tr>
<td></td>
<td>* Exchange transfusion</td>
</tr>
<tr>
<td></td>
<td>* G-CSF, M-CSF</td>
</tr>
</tbody>
</table>
MISCELLANEOUS PROBLEMS

• METABOLIC
  • Hypocalcemia
  • Hypomagnesemia

• HEMATOLOGICAL
  • Thrombocytopenia
  • Neutropenia
  • ↑PT, ↑APTT
  • ↑FDP

• HEMATOLOGICAL
  • Exaggerated Physiological Jaundice

• RESPIRATORY
  • Apnea
  • Pulmonary Hemorrhage

• CARDIAC
  • Persistent Fetal Circulation (PFC)
  • PDA

• CNS
  • Intraventricular Hemorrhage (IVH)

• GASTROINTESTINAL
  • Necrotising Enterocolitis (NEC)
  • Perforation
DANGER SIGNS (SUMMARY)

* Lethargy
* Bleeding
* Hypothermia
* Yellow palms/Soles
* Respiratory Distress
* Excessive wt. loss
* Cyanosis
* Vomiting
* Convulsion
* Diarrhea
* Abdominal distention
TRANSPORT OF LBW

Essential Function of ideal transport
- Ability to provide warmth
- Facilities for observation & Monitoring
- Medication administration & Incubator if necessary
- Easy attachment of additional equipment
- Easy portability
- Easy cleaning & disinfection

Available Transport Incubators
- Transport incubator with no heat source
- Warm water transport incubator
- Electrically generated transport incubator

Essential Equipments
- Medicines - Adr, Naloxone, 10% Dex, NS, Pheno, Aminophylline etc
- Equipments - Ambu Bag, Mask, Laryngoscope, ETT, Monitors
- Nursing supplies - 24G Neoflon, 1,2,10ml syrings, Stethoscope, IFT

**Good Referral Notes & Trained person accompany the baby**

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PROGNOSIS FOR LBW

MORTALITY

*Directly related to severity of complications
*Inversely related to birth weight & gestation

LONG TERM OUTCOME

*Depends on birth weight, gestation and severity of complication

*VLBW - SGA babies ↑ Risk of reduced growth & development
# TACKLING MAJOR CAUSES OF NEONATAL DEATHS

<table>
<thead>
<tr>
<th></th>
<th>Feasibility of care</th>
<th>Complexity of skills required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>At facility</td>
</tr>
<tr>
<td>LBW &lt;1500G</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>LBW-1750g</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>LBW&gt;1750g*</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>SEPSIS</td>
<td>Some</td>
<td>Yes</td>
</tr>
<tr>
<td>Asphyxia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injuries</td>
<td>Difficult</td>
<td>Mostly</td>
</tr>
<tr>
<td>Malformation</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*Nearly 90% LBW neonates are in this category*
### Fetal, Neonatal/Infancy & Adult Disorder & That Might Result From Fetal Programming as a Consequence of Fetal Undernutrition at Different Stages of Gestation

<table>
<thead>
<tr>
<th>Trimester of Pregnancy</th>
<th>First</th>
<th>Second</th>
<th>Third</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consequences</strong></td>
<td>- Low growth trajectory</td>
<td>Disturbed fetal placental relationships</td>
<td>Brain growth sustained but not body</td>
</tr>
<tr>
<td><strong>Fetal adaptation</strong></td>
<td>- Down regulation of Insulin resistance/deficiency</td>
<td>Insulin resistance</td>
<td>Growth factor(s)</td>
</tr>
<tr>
<td><strong>Anthropology</strong></td>
<td>- Symmetric</td>
<td>Mixed</td>
<td>Asymmetric</td>
</tr>
<tr>
<td><strong>Infant growth</strong></td>
<td>- Reduced</td>
<td>Reduced</td>
<td>Catch-up growth possible</td>
</tr>
<tr>
<td><strong>Adult life</strong></td>
<td>- ↑BP</td>
<td>↑BP, NIDDM</td>
<td>↑BP, NIIDM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IHD</td>
<td>IHD</td>
</tr>
</tbody>
</table>

**Hypercholesterolemia**

Barlerd D, Mothers, babies & diseases later in life, London; BMJ: 1994
Neonatal Plea to those who care

- If I am going to be born preterm and small, please give my mom steroids & help me survive
- Don’t allow me to contaminate amniotic pool with my meconium. If so, take me out at earliest & help me survive
- During labor, I am traveling through narrowest passage in my life. I may be in trouble. Please be there, fully armed to help me in case, If I need it
- Despite your help, if I am in trouble, help me to transport to nearest good center

If you help me and give me good start, I will remember you for ever
Thank You