THE FOLLOW-UP OF THE RISK NEWBORN BETWEEN HOSPITAL AND COMMUNITY: THE ROLE OF FAMILY PEDIATRICIAN

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[Il follow-up del neonato a rischio tra ospedale e territorio: ruolo del pediatra di famiglia]

SUMMARY

Objectives. To emphasize the role of the family pediatrician (FP), as first actor of children primary cares and the continuous assistance on the community, from birth to the adolescence, must manage also the little risk patients, with equal accesses and visits if not advanced to the healthy child, without any precise public plan to which making reference.

Material and methods. To estimate inside of the years 2004-2008 the number of newborns taken in care, calculating between these the number of healthy newborns, the number of risk newborns and the total number of accesses carried out for everyone.

Results. On an average of 105 newborns for year, registered from the healthy local district, approximately 65 newborns per year were taken in care after the birth, while risk newborn have turned out to be in average 6,6 the year. The analysis of the data has shown that the activity carried out in favour of the newborn risk has represented 27% of the visits and 22% of the health.

Conclusions. To devoid forehead of, if not absent, precise plan of attendance and taken in care of the healthy newborn, rather than of the risk newborn, the family pediatrician attendance to both faces such necessity guaranteeing, with a recording of such chosen on the working activity not to underrate.

Key words: Follow up of the risk newborn, visits and budgets of health, role of Pediatrician

RIASSUNTO

Obiettivi. *Sottolineare il ruolo fondamentale del pediatra di famiglia, che in qualità di primo rappresentante delle cure primarie e dell'assistenza continua del bambino sul territorio, dalla nascita all'adolescenza, deve gestire anche i piccoli pazienti a rischio, con accessi e visite pari se non superiori al bambino sano, senza che vi sia alla base un preciso progetto a cui fare riferimento.*

Materiali e metodi*. Valutare all'interno del quinquennio 2004-2008 il numero di neonati presi in carico, calcolando tra questi il numero di neonati sani, il numero di neonati a rischio e il totale numero di accessi effettuati per ciascuno.*

Risultati*. Su una media di 105 nuovi nati per anno, assegnati al PdF dal distretto sanitario competente, circa 65 l'anno erano presi in carico subito dopo la nascita, di questi i neonati a rischio sono risultati essere in media 6,6 l'anno. L'analisi dei dati ha mostrato che l'attività svolta in favore dei neonati a rischio ha rappresentato il 27% delle visite ed il 22% dei bilanci di salute.*

Conclusione*. A fronte di un carente, se non assente, preciso progetto di assistenza e presa in carico del neonato sano, piuttosto che del neonato a rischio, il pediatra di famiglia affronta tale necessità garantendo un assistenza ad entrambi, con un'incidenza di tale scelta sull'attività lavorativa da non sottovalutare.*

Parole chiave: *Assistenza continua dei neonati a rischio, visite e bilanci di salute, ruolo del Pediatra*

Introduction

Italian family pediatrician (FP), works inside the primary care and guarantees the assistance to the child on the community, within of National Health System[1,2]. In Europe and in the world he represents the only example of continuative and total extra hospital assistance.

FP role, is still not fully known, cause the absence of an effective system report and verifying of the real activity.

They do not exist, in fact, of the appropriated feedbacks in order to estimate the entity and the impact on the community of the attendance distributed from FP[3].

In the last decade, moreover, they are subentries of the charitable innovations, previously carried out in not organized way and, therefore, little valued, but that today they have been structured like integrating part of the activity of a FP, which: routine health-checks, the assistance to the chronic sick children, the care of newborns and adolescents[4].

A detail engagement of the FP is the taken in care of the risk newborns for the clinical instability and its adaptation. Even if not necessarily, for the

newborn to be preterm means to be pathological, the equilibrium in order to favor the auxologic increase and a normal psychomotor development is so precarious that is favorable always a charitable continuity between hospital and home care and it in the first instance comes true with a good acquaintance parent-child, than only the FP can have for its constant vicinity with the family[5].

In the event specific, the role of the FP is the early identification of alarm signs (red flags) of rebelling or aggravating themselves of a relative pathology to the neonatal risk, the management of the therapy prescribed from the neonatal intensive care of origin and the coordination of the activities that the newborn will have to be subordinate in its follow-up[6].

Material and methods

We have estimated the number of newborn who the FP has taken in care in five-year period 2004-2008, calculating the number of healthy newborn taken soon in care, the number of risk newborn taken soon in care and the total number of accesses carried out for everyone. Regarding the accesses in outpatients' schedule, for every risk newborn, they have been programmed, for all the first year of life, beyond the routine health-checks (1, 2, 3, 4, 5, 6, 8, 10 and 12 months), 2 visits to the month for the first 3 months, 1 visit to the month till the fulfillment of the year, while for the healthy newborns the health budgets have been programmed only[7].

Results

In five-year period 2004-2008, to the FP they have been assigned, from the NHS, through the choice of the family, an average of 105 new ones been born for year (minimal 93, maximum 117); of these an average of 65 the year (approximately 62%), came quickly taken in care after the birth, to the demission's from the structure that has operated the delivery. The risk newborn have turned out to be in average 6,6 the year (representing approximately 10% of all the newborn taken in care), with pathology more common: neonatal distress, prematurity, congenital cardiopathy, neonatal encephalitis, etc. (Table 1).

Analysis of the data has shown that in the five-year period we have been carried out, for the new ones been born of the year, an average of 285 visits (with a 228 minimum of and a maximum of 333) and an average of 314 of routine health-checks (with a 287 minimum of and a maximum of 342), while for the newborn risk they have been carried out the year an average of 77 visits (with a 49 minimum of and a maximum of 141) and an average of 68 budgets of health (with a 44 minimum of and a maximum of 111). The activity carried out in favour of the risk newborn has represented 27% of the visits and 22% of the health budgets (Table 2).

Discussion

On the contrary of other Italian regions, in Sicily, it does not exist, on the community, a precise plan of neonatal care after the delivery, neither of the risk newborns.

This category is without a doubt much wide comprising newborns preterm, of low weight to the birth, small for gestational age affections from a congenital pathology them or in the worse one of the cases, hit from a malformation[8].

Everyone of the cited cases needs of an attention detail from the FP that must therefore devote them to greater time and resources. This not paltry engagement meets, as we said, with the lack of a prearranged program, thought and studied in order to make forehead to the management of this category of patients without but omitting the conduction of the normal activity turned to the rest of the accesses.

We can therefore assert that, in spite of indifference of the institutions, the FP takes in care however of the newborn and in particular it assists since the birth very 65% of all the new ones been born that they come to it enrolled and of these 10% are represented from risk newborns.

Analyzing the carried out activity, this 10% of newborns, records in the working activity for 27% of the visits (with tips near 50%) and for 22% (with a maximum of 33%) of all that dedicated to the newborns of the year, to demonstration that risk newborn is however a child to follow and to assist step by step in its increase and the FP, besides being the better operator, he is much sensitive to the problems of the children and their family.

YEAR	BIRTH COHORT	TOTAL NEWBORNS TAKEN IN CARE		HEALTHY NEW-BORNS		RISK NEW-BORNS	
		N.	%	N.	%	N.	%
2004	107	75	70	67	89	8	11
2005	114	54	47	50	93	4	7
2006	117	69	59	61	88	8	12
2007	96	65	68	57	88	8	12
2008	93	62	67	57	92	5	8
AVERAGE±DS	105.4±9.9	65.0±9.2	(62%)	58,4±7,1	(90%)	6,6±2,1	(10%)

Table 1: Population in study.

YEAR	HEALTHY NEWBORNS				RISK NEWBORNS			
	VISITS		ROUTINE HEALTH-CHECKS		VISITS		ROUTINE HEALTH-CHECKS	
	N.	%	N.	%	N.	%	N.	%
2004	233	100	324	100	49	15	44	14
2005	228	100	287	100	64	28	47	16
2006	325	100	334	100	75	23	111	33
2007	255	100	309	100	119	47	71	23
2008	287	100	342	100	141	49	68	20
AVERAGE±DS	65.0±9.2		58,4±7,1		6,6±2,1	(27%)		(22%)

Table 2: Result of the carried out activity.

References

1) G.C. Murcio: *La pediatria di libera scelta*. Riv Ital Pediatr. 1995; 21(suppl): *44-54*.
2) S. del Torso, R. Bussi, T.G. DeWitt: *Primary Care Pediatrics in Italy: Eighteen Years of Clinical Care, Research, and Teaching Under a National Health Service System*. Pediatrics 1997; 99(1), E8.
3) MacFarlane: *Organizzazione e ricerca nei servizi pediatrici di base*. Medico e Bambino 5(10):14, 1986.
4) *Accordo collettivo nazionale per la disciplina dei rapporti con i medici specialisti pediatri di libera scelta*. Decreto del Presidente della Repubblica 21 ottobre 1996, n. 613. Gazzetta Ufficiale n. 285 del 5-12-1996, Suppl. Ordinario n. 213.
5) Strain, J.E AAP Periodicity Guidelines: *A Framework for Educating Patients Pediatrics* 1984: 74, *924-927*.
6) American Academy of Pediatrics: Committee on Practice and Ambulatory Medicine: Recommendations for Preventive Pediatric Health Care. Pediatrics 2000; 105; *645-646*.
7) P. Becherucci, L. Biancalani, R. Bussi, M. Generoso, V. Murgia, M. Pierattelli, E. Solito, P. L. Tucci: *I bilanci di salute: uno strumento di medicina preventiva*. Area Pediatrica 2004, 5: *3-21*.
8) P. Baeckert, Zollikerberg; C. Bigler, Berna; H.U. Bucher, Zurigo; V. Büttiker, Zurigo; P. Donati, Bellinzona; H. Malzacher, San Gallo; R. Pfister: *Presa a carico di prematuri a partire dalla 34 0/7 fino alla 36 6/7 settimana di gestazione*. Pediatrica Vol. 16 No. 1 2000.

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