

Table 1 Standard "Hypoglycaemia in at risk term infants" public consultation comments

ID	Country	How would you rate the overall quality of the standard "Hypoglycaemia in at risk term infants"?	Do you have any recommendations on how to improve the standard "Hypoglycaemia in at risk term infants" (e.g. rational, benefits, components)?		Is there any important evidence or useful guidelines you would recommend to be included in the standard "Hypoglycaemia in at risk term infants"?		Do you think the standard "Hypoglycaemia in at risk term infants" is relevant in your country?		Do you have any conflict of interest (e.g. financial support or consulting of industry)?		Please specify if you are responding as an individual or on behalf of an organisation.
			Response	Yes - Please make your recommendation(s) below.	Response	Yes - Please specify below, which evidence should be added (DOIs, references) to the standards and why.	Response	No - Please specify below why the standard is not relevant in your country.	Response	Yes - Please enter your conflict(s) of interest.	
1	United Kingdom	4	No		No		Yes		No		Neonatal Nurses Association
2	Czech Republic	4	No		No		Yes		No		Individual
3	Estonia	5	No		No		Yes		No		Estonian Society of perinatology
4	Greece	4	No		No		Yes		No		Hellenic Midwives Association
5	United States	4	Yes - Please make your recommendation(s) below.	Since this document Presents that different organizations are suggesting slightly different low glucose threshold, it is highly recommended that very strong emphasis is placed for those who are observing 'term' and 'healthy' infants that any of the below instances can easily cause additional risk for infant to develop hypoglycemia, difficult and stressful delivery, prolonged fetal distress, such as repeated late decels, non-reassuring tracing of any kind (indicative of placental insufficiency or other), unrecognized maternal diabetes (LGA should raise an alert),...etc that in our practice, we train our staff to observe as if infants have risk factors, rather than assuming infants are healthy. Unknown health history and such often find it way into these so called healthy infants. Encouraging the skin to skin to reduce infant's caloric expenditure is also something we practice.	Yes - Please specify below, which evidence should be added (DOIs, references) to the standards and why.	https://pubmed.ncbi.nlm.nih.gov/32381469/ This work demonstrated that among the healthy term infant plasma glucose concentrations of 47 mg/dL (2.6 mmol/L) approximated the 10th percentile in the first 48 hours, meaning that greater number of term infants had much higher glucoses. Detail of this paper is highly suggestive that we should stick to a bit higher threshold.	No - Please specify below why the standard is relevant to add to what we already have.	No		COINN	
6	Poland	4	Yes - Please make your recommendation(s) below.	Taking into account the fact that everyone caring for a newborn (young doctors, nurses, midwives) should be alert to the symptoms of hypoglycaemia, I would list the most common clinical symptoms that may accompany low glucose levels	No		Yes		No		Individual
7	Portugal	5	No		No		Yes		No		Associação Portuguesa de Enfermagem Pediátrica e Neonatal
8	Portugal	4	Yes - Please make your recommendation(s) below.	Oral glucose gel (also known as dextrose gel) is a non-invasive and inexpensive treatment option that can be administered on the postnatal ward to infants at risk of hypoglycemia	Yes - Please specify below, which evidence should be added (DOIs, references) to the standards and why.	It will be interesting to include references to Oral glucose gel	Yes		No		Portuguese Society of Neonatology
9	Slovakia	5	No		No		Yes		No		Section of Nurses Working in Neonatology, part of the Slovak Association of Nurses and Midwives is an organizational unit of the Slovak Medical Society
10	Czech Republic	3	Yes - Please make your recommendation(s) below.	Very complex and very complicated topic. I would more emphasize 1) risk factors for developing severe or profound hypoglycaemia - most of infants are SGA or late-preterm 2) most hypoglycaemias associated with brain injury occur in situation of insufficient lactation, especially in women after first pregnancy 3) time span after the birth and situation when hypoglycaemia occurs (e.g. 2 hours vs 2 days - requires complete different approach, similarly metabolic demands in different clinical scenarios (postresuscitation-sepsis-RDS ... vs completely stable risky child with asymptomatic borderline hypoglycaemia)	Yes - Please specify below, which evidence should be added (DOIs, references) to the standards and why.	McKinlay CJD, Aisweiler JM, Ansell JM et al. Neonatal glycaemia and neurodevelopmental outcomes at 2 years. N Engl J Med 2015; 373:1507-1518. McKinlay CJD, Aisweiler JM, Anstice NS et al. Association of neonatal glycaemia with neurodevelopmental outcomes at 4.5 years. JAMA Pediatr 2017; 171:972-983. Shah R, Harding J, Brown J, McKinlay C. Neonatal Glycaemia and Neurodevelopmental Outcomes: A Systematic Review and Meta-Analysis. Neonatology 2019; 115: 116-126. Harding JE, Hegarty JE, Crowther CA et al. Evaluation of oral dextrose gel for prevention of neonatal hypoglycemia (hPOD): A multicenter, double-blind randomized controlled trial. 2021; PLoS Med 18(1): e1003411. https://doi.org/10.1371/journal.pmed.1003411	I don't know	No		Czech Neonatal Society	
11	Romania	5	No		No		Yes		No		ANMGCS

				<p>The document appears to focus only on "at risk infants" which appear to be identified at or soon after birth on the basis of obstetric factors, gestation, birth weight, condition at birth etc. I have seen a number of infants who initially had none of the risk factors for hypoglycaemia, but became hypoglycaemic after 48-72 hours without anybody noticing that they had not actually ingested significant calories since birth. These infants were given only routine care by midwives, and were breast fed without any paediatric supervision. The initial examination of the newborn was carried out by a midwife and nothing abnormal found. The first-time mothers were given initial instructions on breastfeeding and then left to get on with it with the midwife looking in every few hours. In one case, the mother was discharged home 48 hours after birth (by Caesarean with Apgars 8 at 1 minute and 9 at 5 minutes and birth weight 3400g). The mother had no idea whether the baby was actually ingesting milk. After about 62 hours, a community midwife visited, and recognised the baby was pale and unresponsive. On arrival at hospital, the baby was convulsing and had blood glucose 0.6 mol/L. He had lost 400g in weight. Encephalopathy followed with no evidence of any other metabolic disease, infection or any other pathology. The child survived seriously disabled with MRI brain appearances typical of hypoglycaemia. In another case, An infant was born by normal delivery at term in a midwife-only unit. He was examined and no abnormality found. Normal birth weight. The first-time mother tried to breastfeed and was occasionally observed. After about 3 days, the child reluctant to feed and was transferred for paediatric assessment. On arrival at a paediatric department, he was immediately recognised to be poorly responsive, and poorly perfused. He had lost 12% of birth weight. Blood glucose was 0.8 mol/L. He continued to have seizures which eventually stopped with anticonvulsant therapy. No evidence of hypoxic injury or any other metabolic disease. Echocardiography showed he had transposition of the great arteries and a ventricular septal defect. His cardiac condition had presumably impaired his feeding but nobody noticed. He went through the surgery for TGA without complications but has serious disability with the typical hypoglycaemia pattern on MRI brain scan. Brain damage in both cases could easily have been avoided if the lack of milk intake had been detected and a simple heelprick blood glucose measured. Thus the problem with defining a minority of newborns as "at risk for hypoglycaemia" soon after birth is that infants not within the at risk group may not have hypoglycaemia considered even as a remote possibility. "Keep everything natural and do not medicalise" This is particularly so when a first time mother is trying to breastfeed. In some cases, midwives have clearly not detected that the infant was ingesting negligible amounts of breast milk and have not used the simple technique of weighing the baby (clothes, diaper, urine and everything) before and after a feed to measure, not the baby's true weight, but the difference between before and after a feed. Dismiss these anecdotes as low quality evidence if you dare! Where are your hypoglycaemia guidelines for infants who are not at risk?</p>						
12	United Kingdom	3	Yes - Please make your recommendation(s) below.		<p>Yes - Please specify below, which evidence should be added (DOIs, references) to the standards and why.</p>	<p>Although assessment at birth can identify infants at risk of hypoglycaemia, healthcare professionals should realise that risk can change over time. Inexperienced attempts at breastfeeding for the first time can lead to negligible calorie intake over 48 hours or longer and this can lead to hypoglycaemia even in infants not initially at risk. Inadequate milk intake needs to be suspected and, if confirmed, a bedside blood glucose is needed even if the infant does not show signs of illness. I also do not see any reference to hypoglycaemia in the context of hypoxic-ischaemic encephalopathy. There is very good evidence that moderate hypoglycaemia during hypoxic-ischaemic encephalopathy worsens brain injury. This is very well reviewed in "Neurology of the Newborn" by Jo Volpe. There is extensive review of the evidence on this subject. Blood glucose levels that would not cause concern in a "normal" infant are still considered too low in HIE.</p>	<p>No - Please specify below.</p>	<p>Not as relevant as they could be for the reasons above.</p>	No	Individual
13	Germany	3	No		No		Yes		No	Individual
14	Kosovo	5	No		I don't know		Yes		No	QKUK
15	Italy	5	No		No		Yes		No	Individual
16	Poland	4	Yes - Please make your recommendation(s) below.	See below	<p>Yes - Please specify below, which evidence should be added (DOIs, references) to the standards and why.</p>	<p>Special attention require in newborns with macrosomia and late premature babies. In these newborns concentration of blood glucose should be check as soon as possible after birth and breastfeeding should be started. If breastfeeding does not provide sufficient needs formula should consider.</p>	<p>No - Please specify below.</p>	<p>In Poland for several years we have had standards updated every two years The current version of 66 standards was publish in March this year.</p>	No	Coalition for Premies
17	Ukraine	5	No		No		Yes		No	Individual
18	Hungary	5	No		I don't know		Yes		No	Melletted a helyem Egyesulet
19	Croatia	5	No		I don't know		Yes		Yes - Please enter your conflict(s) of interest.	Cooperation with Nutricia and Thermo Fisher Scientific. Croatian Society for Neonatology and Neonatal Intensive Medicine