

## 10 Cosas que deberías saber sobre... ...la lactancia artificial



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Las fórmulas infantiles basadas en proteínas de leche de vaca deben ser la primera opción en aquellos lactantes sanos no alimentados al pecho

Las diferencias de las fórmulas de continuación respecto a las de inicio son escasas (proporción caseína/seroproteínas y mayor cantidad de hierro). Pueden contener aunque no se recomienda sacarosa y fructosa

Existen fórmulas artificiales en las que se han modificado algunos de sus componentes (hidratos de carbono, proteínas o grasas) para los lactantes con limitaciones con limitaciones digestivas, metabólicas o problemas de intolerancia/alergias

Las fórmulas sin lactosa están indicadas en: déficit congénito de lactasa, intolerancia secundaria a la lactosa y glucogenosis tipo I

La mayoría de los niños con gastroenteritis aguda pueden continuar recibiendo una fórmula con lactosa

Las fórmulas con contenido graso en forma de triglicéridos de cadena media están indicadas en paciente con alteraciones linfáticas y del metabolismo lipídico (abetalipoproteinemia, ascitis quílosa, linfangiectasia intestinal...)

Las fórmulas hidrolizadas se encuentran indicadas en el tratamiento de la alergia a la proteína de leche de vaca

Las fórmulas de soja pueden considerarse en mayores de 6 meses con alergia mediada por IgE, debido a su bajo coste y mejor aceptación que las fórmulas hidrolizadas, aunque con prueba de provocación previa

Las fórmulas elementales precisan una mínima digestión y están indicadas en situaciones con una grave alteración de la función digestiva, como paso intermedio desde una alimentación parenteral y en casos de alergia/intolerancia a las proteínas de la leche de vaca que no responden a hidrolizados

No existen evidencias suficientes para recomendar el uso de fórmulas antiestreñimiento, anticólicas y antirregurgitación



# The Corner

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## 5. Role play: Rounding the floor. Resident presenting patient with community-acquired pneumonia to attending physician

**Resident:** James is a six-year-old, obese male who presents with a four day history of fever, cough and abdominal pain. He presented daily fevers as high as 39.5°C which respond well to common antipyretics. The patient also reports mild cough for the last four days, as well as mild abdominal pain which is described as diffuse. His mother says that the patient seems more inactive than usual, associating hyporexia. In the physical examination he was found to have crackles in his right inferior lobe with mild respiratory distress, so a chest x-ray was performed. A consolidation was seen in the right inferior lobe with minimum blunting of the right costophrenic angle. The patient was finally diagnosed with pneumonia associated with pleural effusion. His oxygen saturation levels came down to 88%, so he was admitted to the floor and supplemental oxygen and empiric antibiotic therapy with ampicillin was initiated.

**Attending:** Has the parapneumonic pleural effusion been evaluated using ultrasonography?

**Resident:** Yes, the imaging confirmed the presence of fluid in the pleural space but it was of small quantity, only with dimensions of 0.5 cm x 0.7cm, and no loculations or septations were observed, so there was no indication for drainage of the pleural fluid.

**Attending:** Very well. So with the blood test results and the disease history what type of bacterial infection do you think James has?

**Resident:** The complete blood count showed a white blood cell count of 17.500/microL with left shift. Concerning the acute phase reactants, we found a C- reactive protein of 132mg/L and serum procalcitonin of 1.2ng/ml. So with all the results we suspect he has a bacterial infection rather than an atypical bacterial pneumonia or a viral infection. However we are waiting for the results of the blood culture and the serologic tests.

**Attending:** How has James evolved since his admission? Has the fever disappeared? Does he still need oxygen supplementation?

**Resident:** The fever disappeared within 24 hours of his admission along with his respiratory distress. Today he no longer needed oxygen supplementation to maintain adequate oxygen saturations. Serum electrolytes have had normal values with no signs of dehydration or syndrome of inappropriate antidiuretic hormone secretion. In the follow up blood test neutrophil counts have reached normal values, as well as the acute phase reactants.

### KEY WORDS:

Rounding the floor: pasar planta de hospitalización.

Attending physician: médico adjunto.

Antipyretics: antipiréticos.

Crackles: crepitantes.

Chest x-ray: radiografía de tórax.

Consolidation: consolidación.

Blunting/obliteration of the right costophrenic angle: borramiento del seno costofrénico.

Pleural effusion: derrame pleural.

Supplemental oxygen: oxigenoterapia.

Ultrasonography: ecografía.

Pleural space: espacio pleural.

Complete blood count (CBC): hemograma.

White blood cell count (WBC): serie blanca del hemograma.

Left shift: desviación izquierda.

Acute phase reactants: reactantes de fase aguda.

C- reactive protein (CRP): proteína C reactiva.

Serum procalcitonin (PCT): procalcitonina.

Blood culture: hemocultivo.

Serologic tests: pruebas serológicas.

Serum electrolytes: electrolitos en suero.

Syndrome of inappropriate antidiuretic hormone secretion (SIADH): síndrome de secreción inadecuada de ADH.



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