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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 the number of 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.

**Conclusioni.** 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\(^1\)^\(^2\)\(^3\). In Europe and in the world he represents the only example of continulative 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\(^3\)^\(^4\).

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\(^4\)^\(^5\).

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 acquain-
tance 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 
eyearly 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 new-
born taken soon in care, the number of risk new-
born 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 program-
med 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 approxima-
tely 10% of all the newborn taken in care), with 
pathology more common: neonatal distress, prematu-
rity, 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 
one's 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 mini-
mum of and a maximum of 141) and an average of 
68 budgets of health (with a 44 minimum of and a 
imaximum 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 atten-
dition 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 cate-
gory of patients without but omitting the conduc-
tion of the normal activity turned to the rest of the 
accesses.

We can therefore assert that, in spite of indiffe-
rence of the institutions, the FP takes in care howe-
ever 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 pro-
blems of the children and their family.
<table>
<thead>
<tr>
<th>YEAR</th>
<th>BIRTH COHORT</th>
<th>TOTAL NEWBORNS TAKEN IN CARE</th>
<th>HEALTHY NEWBORNS</th>
<th>RISK NEWBORNS</th>
</tr>
</thead>
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<tr>
<td></td>
<td></td>
<td>N.</td>
<td>%</td>
<td>N.</td>
</tr>
<tr>
<td>2004</td>
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<td>75</td>
<td>70</td>
<td>67</td>
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<tr>
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<td>54</td>
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<td>50</td>
</tr>
<tr>
<td>2006</td>
<td>117</td>
<td>69</td>
<td>59</td>
<td>61</td>
</tr>
<tr>
<td>2007</td>
<td>96</td>
<td>65</td>
<td>68</td>
<td>57</td>
</tr>
<tr>
<td>2008</td>
<td>93</td>
<td>62</td>
<td>67</td>
<td>57</td>
</tr>
</tbody>
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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.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>HEALTHY NEWBORNS</th>
<th>RISK NEWBORNS</th>
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<td></td>
<td>VISITS</td>
<td>ROUTINE HEALTH-CHECKS</td>
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<td></td>
<td>N.</td>
<td>%</td>
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<td>2005</td>
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<tr>
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<tr>
<td>2007</td>
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<td>100</td>
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<tr>
<td>2008</td>
<td>287</td>
<td>100</td>
</tr>
</tbody>
</table>

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


