Acute neonatal respiratory failure and *Chlamydia trachomatis*

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Neonatal infection with *Chlamydia trachomatis* is not an uncommon problem. However, severe infection leading to respiratory failure is a rare complication, and it has only been described in very preterm babies. We describe a case of respiratory failure needing ventilation following chlamydial infection in a neonate of 36 weeks’ gestation.

**Case report**

A 2 weeks old male neonate, born following vaginal breech delivery at 36 weeks’ gestation with a birth weight of 2.13 kg, was admitted with history of apnoeal attacks and blue discolouration of the face and lips. In his short history he had a previous hospital admission when he was 3 days old for physiological jaundice which needed phototherapy. His parents had been in a steady relationship for the previous 6 years.

Clinical examination on the paediatric assessment unit revealed a generally healthy neonate with a blood pressure of 61/38 mm Hg (range 70/40), pulse of 142/minute, temperature of 35.8°C, body weight of 2.3 kg, respiratory rate (RR) of 80/minute, and oxygen saturation (O2 sats) of 80% on air rising to 93% on oxygen. Examination of the respiratory, cardiovascular, central nervous systems, and the abdomen was unremarkable. The chest x-ray showed widespread nodular shadowing in both lung fields with normal heart size (fig 1) and, accordingly, a diagnosis of bronchiolitis was considered and a septic screen sent off.

Capillary blood gas (CBG) analysis showed pH 7.21 (range 7.31–7.43), Pco2 7.84 kPa (range 3.7–5.9), bicarbonate 19.3 mmol/l (range 16.8–21.6), with a base excess (BXS) of −5.8 mmol/l (range −5 to +5).

Both the parents were asymptomatic. However, following their attendance at the genitourinary medicine clinic, *Chlamydia trachomatis* infection was isolated from the genital tract of both.

**Discussion**

If antenatal screening for *Chlamydia trachomatis* is routinely carried out, some neonatal infections could be prevented.1 Prevalence of *C trachomatis* in the antenatal population varies (2%–24%) depending on the population studied.2 However, the risk of vertical transmission from an infected mother is 60%–70%3 with its attendant risks of conjunctivitis, pneumonitis, meningitis, myocarditis, chronic respiratory problems, preterm labour, and respiratory distress syndrome (RDS).4 5 Attenuvorow describes five cases of severe neonatal pneumonia due to *C trachomatis* in preterm babies (25–32 weeks’ gestation) two of whom were delivered by caesarean section; all of them needed ventilation and one of them died.5 Prematurity increases the risks of respiratory failure as was evident in this cohort; however, our case illustrates that even near to term (36 weeks) babies are at risk and can go on to need ventilatory support.

This case demonstrates the need for vigilance and increasing awareness in cases of intractable respiratory conditions in neonates.
which could be reduced by routine third trimester screening for *C trachomatis*.

**Contributions:** Both authors managed the parents and wrote the manuscript.

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*Sex Transm Infect* 2001 77: 135-136
doi: 10.1136/sti.77.2.135

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