

THE MANAGEMENT OF INFANT COLIC



By Dr Sarah Jarvis

The average infant's cry is eminently well designed for its purpose — to alert the parent to the fact that the child is in need. Imagine, then, the impact of a newborn infant crying for at least three hours a day, at least three days a week, for at least three weeks. This — in an otherwise healthy, thriving baby — is the commonly accepted definition of infant colic, and it affects up to 20% of children.¹

OTHER KEY SIGNS INCLUDE :

- Drawing up of the knees
- Wind
- Redness of the face
- Timing of symptoms (often, but not exclusively, in the early evening)
- Failure to respond to normal methods of soothing distress.¹

Colic is a diagnosis of exclusion, and differential diagnosis in the acute setting includes nappy rash, hunger, non-accidental injury, intussusception, volvulus and strangulated hernia. In the longer term, causes include reflux oesophagitis, poor parenting skills or experience and maternal post-natal depression.

While colic is neither life-threatening nor a long-term problem (usually settling by 3-4 months of age), it is deeply distressing for parents and child alike, affecting parent-child bonding, the likelihood of postnatal depression, and even non-accidental injury.

So what can we offer these desperate parents? Reassurance may seem trite, but it can be hugely helpful for parents to realise that the condition is common and transient, and does not reflect their parenting skills or rejection by their baby. It is also essential to help parents to develop coping strategies, including sleeping when the baby is sleeping, and taking time for themselves. New parents often feel guilty at leaving their baby at all, and this is magnified if their self-esteem is low due to their inability to comfort their child effectively. They need 'permission' to admit they need a break.

The mother should be monitored closely for signs of postnatal depression, encouraged to talk to other new mothers, and the health visitor alerted to provide support, the charity CRY-SIS can also offer valuable support (telephone 08451 228 669, website www.cry-sis.org.uk).

REFERENCES

1. NHS Clinical Knowledge Summaries Management of Infantile Colic. Last revised Sept 2007
2. Kanabar et al. J Hum Nutr Dietet, 2001. 14:359-363
3. Moore et al. Jpediatr, 1988. 113:979-984
4. Miller et al. Arch.Dis Child, 1989. 64: 725-729
5. Bar RG. Dev Med Child Neurol, 1990. 32:368-372

STRATEGIES TO SOOTHE THE BABY INCLUDE:

- Holding 'cooing', or rubbing the baby's back or stomach (encourage parents to take turns as this can be distressing if the child continues to cry)
- Rocking or other gentle movement (such as a car or pram ride)
- Giving a warm bath
- Non-specific background noise (soothing music or running water)
- Avoiding to repeatedly pick up the baby, which may overstimulate.

For some parents, reassurance and support is enough to help them through this difficult period. For others, however, an effective medical option offers welcome relief. Simeticone drops have been widely used, but have been found in double-blind cross-over studies to be no better than placebo. Clinical Knowledge summaries acknowledge the lack of evidence but suggest the option on the basis that there are no reported adverse consequences and 'simeticone is easily available, licensed for this indication, and cheap.'¹

The underlying cause of colic is still the subject of debate. In some babies, colic may be due to lactase deficiency, due to an immature digestive system. Lactase deficiency results when lactase from breast or formula milk reaches the colon, where it is broken down by lactobacilli and bifidobacteria, producing lactic acid and hydrogen. The lactic acid increases osmotic pressure, increasing water content and thus distension of the large bowel, and the hydrogen causes bloating and pain. This theoretical mechanism is supported by the finding of increased breath hydrogen in infants with lactase deficiency.^{2,3,4,5}

For infants where lactase deficiency is suspected as a cause of the colic, a one week course of lactase drops (marketed as Colief ®) can provide a diagnostic trial, without the need for the mother to adopt an entirely dairy free diet if breastfeeding or to switch to a hypoallergenic formula (low-lactose and soya formulae are not recommended). If the duration of crying shortens, the Clinical Knowledge Summaries guidelines recommend continuing until at least 3 months of age (and to 6 months at the longest); they do not recommend continuing after a one week trial if there is no response.

In summary, colic is common, transient, non-fatal but highly distressing. Lactase deficiency appears to be at the root of the problem in some patients. The use of lactase drops can act as a diagnostic trial to differentiate babies suffering from lactase deficiency, and may reduce both parental and infant distress and pressure on GP time.

HOW TO USE COLIEF® INFANT DROPS

Colief Infant Drops can be used from birth onwards to help alleviate the discomfort of babies with colic due to temporary lactose sensitivity. Parents should be advised to follow the instructions for Colief to have the best chance of helping their baby.

- For breastfed babies, 4 drops should be added to expressed breast milk and fed to the baby on a sterilised spoon immediately before feeding.
- For babies fed with infant formula, 4 drops should be added to warm formula half an hour before feeding.
- If the formula feed is made up in advance, 2 drops should be added to warm formula and then stored in the refrigerator for a minimum of 4 hours before use.

For further information contact health@forumgroup.co.uk

