Jaundice

Pallor

Petechiae, ecchymosis

Splenomegaly

Supportive therapy usually involves administration of oxygen (if respiratory distress or hypoxia is evident), careful regulation of fluids, correction of electrolyte or acid–base imbalance, and temporary discontinuation of oral feedings. Blood transfusions may be needed to correct anemia and shock, and electronic monitoring of vital signs and regulation of the thermal environment are mandatory.

Antibiotic therapy, usually administered intravenously, is continued for 7 to 10 days if culture results are positive, discontinued in 48 to 72 hours if culture results are negative and the infant is asymptomatic. Antifungal and antiviral therapies are implemented as appropriate, depending on causative agents.

Prognosis

The prognosis for neonatal sepsis is variable. Severe neurologic and respiratory sequelae may occur in ELBW and VLBW infants with early-onset sepsis. Late-onset sepsis and meningitis may also result in poor outcomes for immunocompromised neonates.

The introduction of new markers for neonatal sepsis such as acute phase reactants, cytokines, cell surface antigens, and bacterial genomes may prove to be particularly helpful in guidance for antibiotic therapy (Tripathi and Malik, 2010). Future experimental methods being explored to combat infection in neonates include monoclonal antibody therapy, fibronectin infusion, and lymphokine enhancement.