

infants may need a higher insulin level to effectively reduce hepatic endogenous glucose production or enhance glucose disposal or both. The possibility of a smaller insulin-sensitive tissue mass in LBW infants may be another factor that needs to be explored. In particular, adipose tissue mass is very small in very immature neonates.

The data on urine volume and glucose excretion are of interest in that an osmotic diuresis was not observed, despite a significant increase in serum and urine glucose levels. The net effect is apparent since the tubular water conservation was achieved, probably because the total amount of glucose being excreted constituted an osmolar load that was too small to produce an osmotic diuresis.¹¹

From the clinical standpoint, although 20 gm/kg/day of glucose intake did not result in an osmotic diuresis, hyperglycemia was evident and its effect on brain metabolism is unknown. In Rhesus monkeys, Myers^{12,13} has shown that hyperglycemia may result in significant brain injury when asphyxia is superimposed.

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ACKNOWLEDGMENT

We are grateful to Ms. Jackie Beaudet, Mrs. Barbara Davis, and Mrs. Kathleen Petzold for their technical and laboratory assistance in performing the studies.

CORRECTION

An error was made in the article "Vitamin E and Neonatal Hemolysis" by Gross et al. (*Pediatrics* 59[suppl]:995, June 1977). In "Materials and Methods" on page 995, it states that infants received tocopherol acetate. The infants actually received the free alcohol form of tocopherol.

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