Alert	This medication should only be administered by a medical officer or nurse practitioner.
Indication	Treatment and prophylaxis of respiratory distress syndrome (RDS). Treatment of meconium aspiration syndrome (MAS).
Action	Lowers surface tension on alveolar surfaces during respiration and stabilises the alveoli against collapse at resting trans pulmonary pressures.
Drug Type	Pulmonary surfactant
Trade Name	Curosurf
Presentation	Suspension for intra-tracheal use 120 mg/1.5 mL or 240 mg/3 mL vials
Dosage/Interval	**Respiratory distress syndrome** Loading dose of 200 mg/kg Repeat dose of 100 mg/kg when required every 6–12 hours. Maximum of 3 doses. **Meconium aspiration syndrome** Single dose: 200 mg/kg Further doses can be given as below if required: 2nd dose: 200 mg/kg 3rd dose: 100 mg/kg 4th dose: 100 mg/kg These doses can be administered at 6 hour interval.
Maximum daily dose	
Total cumulative dose	
Route	Intra-tracheal
Preparation/Dilution	Nil
Administration	This medication should only be administered by a medical officer or nurse practitioner. Inspect product visually for discolouration prior to administration (suspension should be white to creamy white). Before use, the vial should be slowly warmed to room temperature (can be warmed in hand or stood at room temperature) and gently turned upside down in order to obtain a uniform suspension. DO NOT SHAKE. Poractant alpha is administered via the endotracheal route using an endotracheal tube (ETT) or thin catheter. ETT administration: Assess patency and position of ETT prior to administration. Clear the trachea of secretions if required. Shorten a 5 French end-hole catheter so that the length of the catheter is 1 cm shorter than the ET tube. Slowly withdraw entire contents of vial(s) into a syringe through a needle (≥ 20 gauge). Do not shake. Attach shortened catheter to syringe. Fill catheter with surfactant. May administer in 1 to 2 aliquots as tolerated with the neonate in neutral supine position. If the infant is on a ventilator, the catheter can be inserted into the infant's ET tube without interrupting ventilation by passing the catheter through a neonatal suction valve attached to the ET tube. This is especially useful in high-frequency ventilation to minimise de-recruitment. Alternatively, surfactant can be instilled through the catheter by briefly disconnecting the ETT from the ventilator. Approximately 2 mL of air may be used to push any remaining surfactant in the catheter into the lungs.

	Thin catheter administration: Use a 4 French end-hole catheter marked approximately 1.5 cm above one end. Connect a syringe and catheter prefilled with surfactant preparation. While the infant is breathing via nasal CPAP, introduce laryngoscope and insert catheter using Magill forceps up to the mark on the catheter. Secure tube position and remove laryngoscope. With the infant's mouth closed, instil surfactant during 30 to 120 seconds by mini-boluses. In cases of apnoea or bradycardia, perform positive pressure ventilation until recovery.
Monitoring	Continuous oxygen saturation and cardiorespiratory monitoring.
Contraindications	None known
Precautions	Correction of acidosis, hypotension, anaemia, hypoglycaemia and hypothermia is recommended by the manufacturer prior to poractant alpha administration but this is not always possible in practice.
Drug Interactions	N/A
Adverse Reactions	Transient: Bradycardia, hypotension, endotracheal tube blockage and oxygen desaturation. These events require stopping poractant alpha administration and taking appropriate measures to alleviate the condition. After the patient is stable, dosing may proceed with appropriate monitoring. Ventilator settings may need to be adjusted post-surfactant to accommodate increased lung compliance.
Compatibility	Poractant alpha should not be mixed with any other medications or fluids.
Incompatibility	N/A
Stability	Vials are for single use only. DO NOT SHAKE. Unopened, unused vials that have warmed to room temperature can be returned to refrigerated storage within 24 hours for future use. Document on the packaging the date and time the product was removed from the fridge. Notify Pharmacy Department/NICU Pharmacist if this occurs. Do not warm to room temperature and return to refrigerated storage more than once.
Storage	Store at 2−8°C. Protect from light.
Special Comments	Surfactant may alter amplitude-integrated electroencephalography (aEEG) recordings after administration.
Evidence summary	Early versus delayed surfactant treatment: Early selective surfactant administration given to infants with RDS requiring assisted ventilation leads to a decreased risk of acute pulmonary injury (decreased risk of pneumothorax and pulmonary interstitial emphysema) and a decreased risk of neonatal mortality and chronic lung disease compared to delaying treatment of such infants until they develop worsening RDS [4, 5] (LOE I, A). Prophylaxis versus rescue treatment: There does not appear to be additional benefit from prophylactic surfactant compared to nasal CPAP and early rescue surfactant [4, 6] (LOE I, GOR B). Method of administration: Post-ventilatory surfactant (after resuscitation) reduces mortality and chronic lung disease 36-40 weeks [7] (LOE II, GOR B). Nasal continuous positive airway pressure (nCPAP) with rescue thin catheter surfactant versus nCPAP with rescue intubation and surfactant reduces the risk of intubation and pneumothorax and reduces the incidence of chronic lung disease [8-12] (LOE I, GOR B). nCPAP with rescue thin catheter surfactant is better tolerated than nCPAP with rescue intubation and surfactant and immediate extubation (InSurE) with no difference in other clinical outcomes [10-12] (LOE I, GOR B).

	Dose: Higher first dose poractant (200 mg/kg compared to 100 mg/kg) reduces need for re-dosing without proven clinical benefit [13,14] (LOE 1, GOR B). Higher dose poractant 200 mg/kg compared to lower dose beractant 100 mg/kg reduces mortality and need for re-dosing [15-17] (LOE 1, GOR B). Multiple doses of surfactant (up to 4) given to infants with ongoing respiratory insufficiency leads to improved clinical outcomes [18] (LOE 1, GOR A). MAS: Surfactant replacement therapy for meconium aspiration syndrome reduces the incidence of respiratory failure [19] (LOE 1, GOR B). Trials used surfactant 100−200 mg/kg every 6 hours up to a maximum 4 doses. Trials reported response from earlier (before 6 hours) and frequent surfactant replacement (every 6 hours for 3−4 doses) [20, 21].
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This RHW document is a modification of Neomed version. Dosage schedules remain the same. However, information on the commercial preparations not used at RHW is deleted. The risk rating is modified as per the local health district policy.

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