NEONATAL POSTNATAL CLINICAL GUIDELINES



Date Issued: January 2012 Date Revised: April 2014 Review Date: January 2014 Authorised by: NCCU Review Team: NCCU 3.1Hyperbilirubinaemia and Jaundice Neonatal Postnatal Clinical Guidelines King Edward Memorial Hospital Perth Western Australia

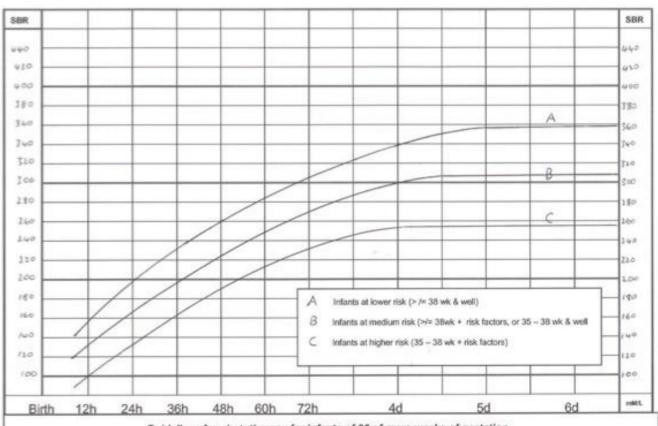
3.1 QUICK REFERENCE GUIDE - JAUNDICE

Transcutaneous Bilirubin Guideline

Note: TcB should be performed in infants ≥35 w gestation and ≥2000gm. Infants at risk of aggressive haemolysis require a low threshold for TcB and/or SBR. TcB should not be relied upon for monitoring serum bilirubin levels following commencement of phototherapy.

Jaundice onset	TcB	Action
<24 hrs		Perform SBR
24-48 hrs	>140 µmol/L	Perform SBR
48-72 hrs	>200 µmol/L	Perform SBR
>72 hrs	>260 µmol/L	Perform SBR

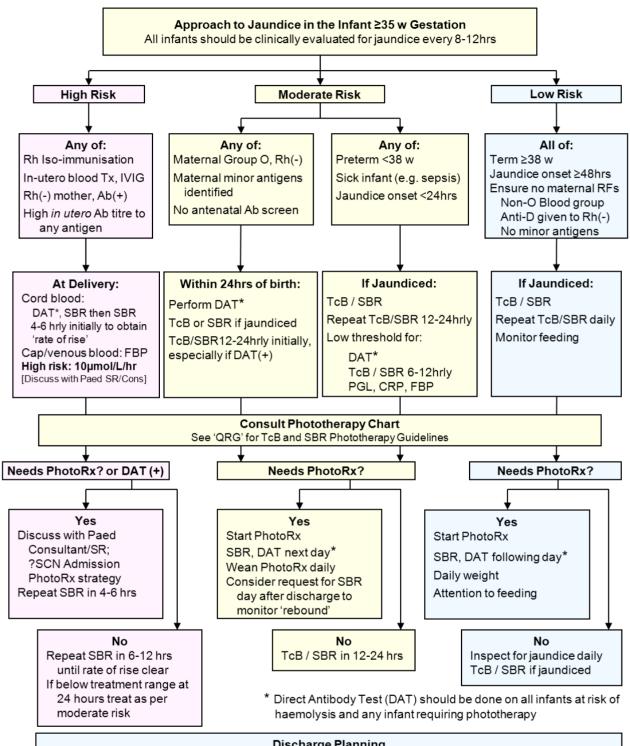
Phototherapy nomogram for the newborn infant ≥35 w gestation.¹



Guidelines for phototherapy for infants of 35 of more weeks of gestation

- Use total bilirubin.
- Risk factors = isoimmune haemolytic disease, G6PD deficiency, asphyxia, significant lethargy, temp instability, sepsis, acidosis.





Discharge Planning

- Consider SBR day after discharge for DAT(+) jaundice needing PhotoRx (VMS collect or in EC)
- Physiological jaundice may be monitored by parents / VMS at home. SBR may be performed prn
- Continuing admission for 24 hours after stopping PhotoRx is not required if the infant is feeding well, weight is <10% below BW and monitoring (via VMS or CHN) is available post-discharge
- Haemolytic jaundice (e.g. ABO, minor antigen or Rh incompatibility) is more likely to 'rebound', has more prolonged course and on occasion may result in anaemia in the weeks after discharge.

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