



CLINICAL PRACTICE GUIDELINE
NEWBORN EMERGENCY TRANSPORT SERVICE (NETS WA)

Pulmonary Haemorrhage

This document should be read in conjunction with the [Disclaimer](#)

Key Points

- A form of fulminant lung oedema.
- Usually complicates other significant disease process e.g. HMD, Meconium aspiration, asphyxia, sepsis, patent ductus arteriosus.
- Rarely as part of bleeding diathesis.

Risk Factors

- Prematurity / Lower birth weight.
- Overwhelming sepsis.
- Hypoxia.
- Left-right shunts causing pulmonary flooding.
- Surfactant administration.
- Severe RDS.


INVESTIGATIONS

- Check Hb, coagulation screen.
- Check ABG, biochemistry.
- CXR: often shows a white-out.
- Look for sepsis.

Management:

- May require ventilation.
- Use higher PEEP (6-7cmH₂O).
- Maintain normal SPO₂.
- Consider surfactant administration: **discuss with the on-call neonatologist.**
- Volume expansion may be indicated. **Avoid over-vigorous fluid administration, which can worsen the condition.**
- In cases where volume overload (e.g. large PDA in preterm infant) is thought to be contributing to pulmonary haemorrhage, consider dose of Frusemide at 1mg/kg.
- Ensure Vitamin K given.
- Avoid unnecessary ETT suctioning.

ALWAYS CONSIDER TAKING NITRIC OXIDE ON RETRIEVAL

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