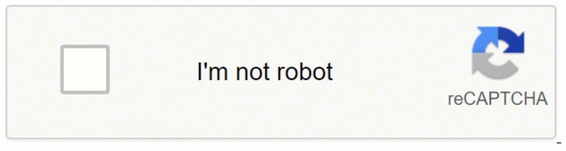


Next

Breastfeeding jaundice nice guidelines

Discussion

- Where does our current practice differ from the recommendations made by NICE about the recognition and assessment of neonatal jaundice?
- When and how often do we currently measure serum bilirubin? What changes do we need to make to enable us to measure serum bilirubin as outlined in the NICE guideline?
- How does our current practice compare to the treatment thresholds recommended by NICE?

Key definitions

Term – 37 weeks or more gestational age
Near-term – 35 to 36 weeks gestational age
Preterm – less than 37 weeks gestational age

Kernicterus – clinical features of acute or chronic bilirubin encephalopathy, including cerebral palsy, hearing loss and visual problems

Prolonged jaundice – jaundice lasting more than more than 14 days in term babies and more than 21 days in preterm babies

Significant hyperbilirubinaemia – an elevation of the serum bilirubin to a level requiring treatment

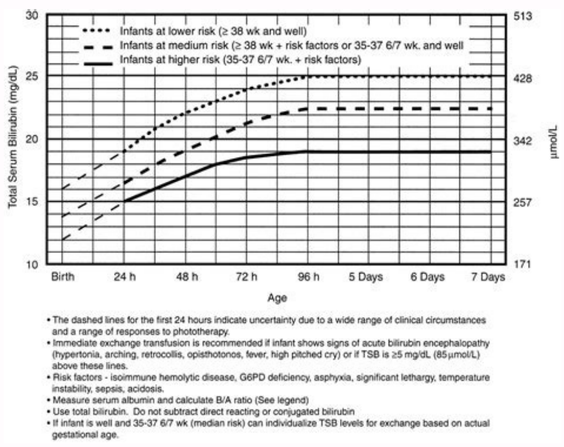
Visible jaundice – jaundice detected by visual inspection

Management of Breastmilk Jaundice

- **Cause not defined**
- **Breastfeeding successfully established yet hyperbilirubinemia persists beyond the fourth week of life**
- **No clear reason to intervene if baby thriving**
- **Recommendation 7.3 – AAP guidelines for management of jaundice**
  - If infant requires phototherapy, breastfeeding should be continued if possible
  - Option to temporarily interrupt breastfeeding and substitute formula to reduce bilirubin levels and enhance efficacy of phototherapy
  - Breastfed infants being treated with phototherapy can be supplemented with expressed breast milk or formula if needed

Reference 3, 17, 27

Breastfeeding Residency Curriculum



- The dashed lines for the first 24 hours indicate uncertainty due to a wide range of clinical circumstances and a range of responses to phototherapy.
- Immediate exchange transfusion is recommended if infant shows signs of acute bilirubin encephalopathy (hypertonia, arching, retrocollis, opisthotonos, fever, high pitched cry) or if TSB is ≥5 mg/dL (85µmol/L) above these lines.
- Risk factors - isoimmune hemolytic disease, G6PD deficiency, asphyxia, significant lethargy, temperature instability, sepsis, acidosis.
- Measure serum albumin and calculate B/A ratio (See legend)
- Use total bilirubin. Do not subtract direct reacting or conjugated bilirubin
- If infant is well and 35-37 6/7 wk (median risk) can individualize TSB levels for exchange based on actual gestational age.

What this presentation covers

Key definitions

Background

Scope

Key priorities for implementation

Costs and savings

Discussion

Find out more

Can breastfeeding make jaundice worse. How to prevent breastfeeding jaundice. Is breastfeeding jaundice dangerous. How often to breastfeed a jaundiced baby.

 1.1.1 Offer parents or guardians information on neonatal itter tailor-made for their expressed needs and concerns. This information should be provided through a verbal discussion supported by written information. Care must be taken to avoid causing useless anxiety to parents or guardians. The information should include: Factors that influence the development of significant hyperbilirubinia How to control the child for the jaundice What to do if they suspect the importance of recognizing the jaundice in the first 24 hours and to look for an urgent medical advice the importance of controlling The baby diapers for dark urine or pale chalky feces the fact that the neonatal jaundice is common, and reassurance that usually is transitory and harmless the reassurance that breastfeeding can usually continue. [2010] 1.2.1 Identify children as inclined to develop significant hyperbilirubinemia if they have one of the following factors: gestational age less than 38 weeks a previous brother with neonatal jaundice that requires phototherapy the mother's intention to breastfeed exclusively visible joy in the first 24 hours of life. [2010] 1.2.2 Ensure that adequate support is offered to all women who intend to breastfeed solely. See the Nice guideline on postnatal care for information on support for breastfeeding. [2010] 1.2.3 In all children: check if there factors associated with an increased likelihood of developing significant hyperbilirubinaemia immediately after birth examine the child for jaundice at any occasion, especially in first 72nd and 160; hours. [2010] 1.2.4 Parents, assistants and healthcare professionals should all seek jaundice (visual inspection) in infants. [2016] 1.2.5 When looking for jaundice (visual inspection): check the naked child in bright light and preferably natural examine the sclera and gums, and press slightly on the skin to check if there are signs of jaundice in the "white" skin. [2016] 1.2.6 Do not rely solely on visual inspection to estimate bilirubin levels in a child with suspected jaundice. [2016] 1.2.7 Do not normally measure bilirubin levels in children who are not visibly jaundiced. [2010] 1.2.8. Do not use any of the following to predict significant hyperbilirubinaemia: end umbilical cord bilirubin level} Carbon oxide (ETCOc) measurement of direct umbilical blood anti-globulin (DAT) (Coombs test). [2010] 1.2.9 Ensure that children with factors associated with an increased likelihood of developing significant hyperbilirubinaemia receive a further visual inspection by a healthcare professional during the first 48th 160; hours of life. [2010] 1.2.10 In all children with suspected or apparent jaundice in the first 24th 160; hours of life, measures and records the serum bilirubin level with urgency (within 2x160hours). [2010] 1.2.11 In all children with suspected or apparent jaundice in the first 24th 160; hours of life, continue to measure the serum level of bilirubin every six to 160; hours until the level is both: below the steady and/or decreasing treatment threshold. [2010] 1.2.12. Provision for a deferral to ensure that an urgent medical review is carried out (as soon as possible and within 6x160; hours) for children with suspected or apparent jaundice in the first 24th 160; hours of life to rule out the pathological causes of jaundice. [2010] 1.2.13 bilirubin levels according to the postnatal age of the child in hours and management of hyperbilirubinaemia according to the threshold table and the treatment threshold charts. [2010] [2010] Measure and urgently record the level of bilirubin (within 6, 160; hours) in all children more than 24ã, 160; Old hours with suspicion or obvious jaundice. [2010] 1.2.15 Use the measure of the bilirubin to serum for newborns: in the first 24th, 160; Hours of life or who have a gestational age less than 35Ã, 160simane. [2016] 1.2.16 in newborns who have a gestational idea of 35Ã, 160simane or more and that are more than 24, 160; Hours of age: use a transcutaneous bilirubino to measure the level of bilirubin a if a transcutaneous bilirubino is not available, measuring the bilirubin to serum if a transcutaneous measurement of the bilirubino indicates a level of bilirubin greater than 250Ã, 160; Micromol / litor, measure serum bilirubin to verify the measurement of serum bilirubin if bilirubin levels are above the relevant treatment thresholds for their age and for all subsequent measurements. [2016] 1.2.17 Do not use a ytterometer to measure bilirubin levels in newborns. [2016] 1.3 [2010] 1.3.2 Encourage mothers of breastfeeded babies with jaundice frequently breastfeeding and to wake the child to feed themselves if necessary. [2010] 1.3.3 Provide support for breastfeeding / breastfeeding to labeled mothers whose child is visibly jaundice. [2010] 1.3.4 Use the level of bilirubin to determine the management of hyperbilirubinemia in all children (see the threshold table and the graphs of treatment thresholds). [2010] 1.3.5 Do not use the albumin / bilirubine report when making decisions on the management of hyperbilirubinemia. [2010] 1.3.6 Do not subtract the bilirubine conjugated by total serum bilirubin when making decisions on the management of hyperbilirubinemia (see management thresholds in the threshold table and the graphs of treatment thresholds). 1.4.1 In infants with good clinical status, they have a gestational age of 38 weeks or more and have more than 24 hours, and a bilirubin level below the phototherapy threshold but not above 50 micromolecule/litre of the threshold (see the threshold table and treatment threshold graphs), repeat the measurement of bilirubin as follows: within 18-hour intervals for children with risk factors for neonatal jaundice (those with a brother who has had neonatal jaundice who needs phototherapy or a mother who intends to breast-feed only) within 24-hour intervals for children without risk factors. [new 2016] 1.4.2 In infants who are clinically well, have a gestational age of 38 weeks or more and have more than 24 hours, and who have a level of bilirubin that is below the phototherapy threshold of more than 50th micromolecule/litre (see the threshold table and treatment threshold charts), do not regularly repeat the measurement of bilirubin. [new 2016] 1.4.3 Do not use phototherapy in children whose bilirubin does not exceed the phototherapy thresholds in the threshold table and treatment thresholds charts. [2010] 1.4.4 During phototherapy: repeat the measurement of serum bilirubin four to six hours after the start of phototherapy repeat the measurement of serum bilirubin every six to twelve hours when the serum bilirubin level is stable or decreasing. [2010] 1.4.5 Discontinue phototherapy once serum bilirubin has dropped to a level of at least 50th micromolecule/litre below the phototherapy threshold (see table of thresholds and treatment thresholds graphs). [2010] 1.4.6 Check the recurrence of significant hyperbilirubinaemia with a repeated measurement of serum bilirubin 12th to 18th hours after discontinuation of phototherapy. Infants do not necessarily stay in the hospital because it happens. [2010] 1.4.7 Do not use sunlight as a treatment for hyperbilirubinemia. [2010] 1.4.8 Use phototherapy [1] to treat significant hyperbilirubinemia (see (see (see Table and charts of treatment thresholds) in children. [new 2016] 1.4.9 Evaluating the possibility to intensify phototherapy[2] to treat significant hyperbilirubinaemia in infants if one of the following conditions applies [new 2016]: serum bilirubin levels increase rapidly (more than 8,5 micromolecules/litre per hour) serum bilirubin is at a level within 50s micromolecule/litre below the threshold for which the interchange transfusion is indicated after 72hours or more since birth (see table of thresholds and treatment thresholds graphs) the level of bilirubin does not correspond to the initial phototherapy (i. e. serum bilirubin levels continue to increase, or do not decrease, within six hours of initiating phototherapy). [2010] 1.4.10 If the serum level of bilirubin decreases during intensified phototherapy to a level of 50th micromolecule/litre below the threshold for which interchange transfusion is indicated, reduce the intensity of phototherapy. [2010] 1.4.11 Provide parents or carers with verbal and written information on phototherapy including all of the following: © Phototherapy is considered because © Phototherapy may be necessary to treat significant hyperbilirubinaemia, the possible negative effects of phototherapy, the need for eye protection and routine reassurance for eye care that short feeding breaks, Changing the diaper and cuddling will be encouraged what could happen if phototherapy fails to bounce the potential long-term adverse effects of phototherapy on breast-feeding and how to minimise this. [2010] 1.4.12 During phototherapy: place the child in a supine position unless other clinical conditions Ensure that the treatment is applied to the maximum zone of the skin monitoring of the child's temperature and ensure that the child is kept in an environment that minimizes energy expenditure (thermoneutical environment), monitor hydration by daily weighing of the child and evaluate if Wet diapers support parents and those who take care of him and They interact with the child. [2010] 1.4.13 Give the baby's eye protection and routine eye care during phototherapy. [2010] 1.4.14 Use the colored head boxes as an alternative to eye protection in children with a 37 week-week gestational or one submitted to a phototherapy. [2010] 1.4.15 During phototherapy: using clinical judgment, encourage short interruptions (up to 30 minutes) for breastfeeding, diapers change and cuddles continue lactation / power supply do not provide further fluids to Switched children breastfeed. Milk Madnal Expred is the additional feed of choice if available and when additional feeds are indicated. [2016] 1.4.16 During intensified phototherapy: Do not interrupt the phototherapy for power supply, but continue to administer intravenous feeds / Enterral continues the support for breastfeeding / feeding so that breastfeeding can start over when the Treatment stops. Express treatment milk is the additional choice feed, if available, and when additional feeds are indicated. [2016] 1.4.17 Make sure that all phototherapy equipment is maintained and used according to the guidelines of the producers. [2010] 1.4.18 Use incubators or bassinet based on clinical needs and availability. [2010] 1.4.19 Do not use white curtains usually with phototherapy as they can compromise the child's observation. [2010] 1.5.1 Identify children with hyperbilirubinemia as an increase in the risk of developing kernicterus if they have one of the following: a serum bilirubin level exceeding 340 micromol / liter in children with a gestational one of 37 weeks or more A rapid increase level of bilirubin higher than 8.5 micromol / at the hour clinical features of acute bilirubin encephalopathy. [2010] 1.6.1 In addition to a comprehensive clinical examination by a properly trained healthcare professional, it performs all of the following tests in children with significant hyperbilirubinaemia as part of an assessment for the underlying underlying basis (see threshold table and treatment threshold diagrams): bilirubin serum (for baseline level to assess response to treatment) Volume of blood cell volume flood (Mother and child test). Interpretate the result taking into account the strength of the reaction and whether the mother received anti-prophylactic immunoglobulin during pregnancy. [2010] 1.6.2 When assessing the child for the underlying disease, considering whether the following tests are clinically indicated: full blood count and blood glucose test of the blood film "6-alpha" phosphate dehydrogenase levels, taking into account microbiological cultures of ethnic origin of blood fluid, urine and/ or cerebrospinal (if infection is suspected). [2010] 1.7.1 In children with a gestational age of 37 weeks or more with jaundice lasting more than 14 days, and in children with a gestational age of less than 37 weeks and joundzio for more than 21 days: look for pale chakky stools and/ or dark urine that stains the diaper measure The conjugated bilirubin does a full blood count perform a blood group determination (mother and child) and DAT (Coombs test) Interpretate the result taking into account the strength of the reaction, and if the mother has received the anti-pathogenic immunoglobulin'During pregnancy perform a urinary culture make sure that routine metabolic screening has been performed (including screening for congenital hypothyroidism). [2010] 1.7.2 Follow expert advice on child care with a level of bilirubin conjugated above 25 micromolecule / litre because © This could indicate severe liver disease. [2010] 1.8.1 Use intravenous immunoglobulin (IVIG) (500 mg/ kg over four hours) as an addition to continuous intensified phototherapy in cases Rhesus hemolytic disease or hemolytic disease ABO When the bilirubine serum continues to rise over 8.5 years micromol / liter per hour. [2010] 1.8.2 Offer parents or accompanying companions On Ivis Included: Why © Ivis is considered the reason why Ivis may be necessary to treat significant hyperbilirubinaemia The possible negative effects of Ivis when it will be possible for parents or companions to see and hold the baby. [2010] 1.9.1 to provide parents or accused persons with information on the interchange transfusion, including: the fact that the interchange transfusion requires that the child be admitted to an intensive cot for you because © an exchange transfusion is considered because © a swap transfusion may be necessary to treat significant hyperbilirubinaemia The possible negative effects of swap transfusions when it will be possible for parents or companions to see and hold the child after the swap transfusion. [2010] 1.9.2 Use a double-volume exchange-rate transfusion to treat children: 1.9.3 During the exchange transfusion do not: INTENSIED PHOTotherapy STOP CONTINUES EXECUTING A SINGLE VOLUME VOLUME USE ALBUMING ALBUMING PRIMING ROODINISTER CALCIO ENRAVENOUS. [2010] 1.9.4. Following interchange transfusion: 1.10.1 Do not use any of the following treatments to treat hyperbilirubinaemia: carbohydrate carbohydrate carbohydrate carbohydrate cholesteramine chlorfibrate from penicillamine glycerine manna metaloporphyrins riboflavin traditional Chinese acupuncture medicine homeopathy. [2010] [2010]

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