

Neonatal Jaundice

Key Points

- This guideline is intended to direct the clinicians and allied Health Professionals in hospital setting and primary care to the most appropriate management of babies with Jaundice based on the NICE guidelines.
- This guideline helps in the recognition, assessment and treatment of neonatal jaundice in babies from birth to 28 days
- All babies with visible jaundice should have a bilirubin level check because of the difficulty of estimating severity by the skin colour.
- Check mother's notes for antibodies, blood group (ABO incompatibility) and ethnicity (G6PD).
- Babies <38 weeks gestation, those who have a previous sibling with neonatal jaundice, those intending to exclusively breast fed (who are having feeding difficulties) and babies visible jaundice at 24 hours age are at risk of significant hyperbilirubinemia.
- Check blood group and Direct Coombs Test (DCT) in babies with jaundice in the first 24 hours of life and in those over 24 hours if slow to respond to phototherapy or if bilirubin rebounds quickly to over treatment threshold.

Version: 2.0

Date Issued: 2 October 2024

Review Date: September 2027

Key words: Jaundice, neonatal jaundice, phototherapy, bilirubin, maternal antibodies

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Abbreviations

DAT	Direct antiglobulin test
DCT	Direct Coombs test
FBC	Full blood count
Hb	Haemoglobin
HbA	Haemoglobin A
HDN	Haemolytic disease of the newborn
IUTs	In utero transfusions
SBR	Serum bilirubin
TcB	Transcutaneous bilirubin

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Treatment Threshold Graphs

CG98 Neonatal jaundice: treatment threshold Available at:

<https://www.nice.org.uk/guidance/cg98/chapter/Recommendations>

1. BACKGROUND

- 1.1 Neonatal Jaundice refers to yellowish discolouration of skin and sclera due to accumulation of bilirubin in skin and mucous membranes. This is associated with raised bilirubin in the circulation termed as **hyperbilirubinaemia**.
- 1.2 Jaundice is common in most newborn infants and is mostly benign. However, because of potential toxicity of bilirubin, new-borns must be monitored.
- 1.3 Approximately 60% term infants and 80% pre- term infants develop jaundice in the first one week of life and about 10% of breastfed babies are still jaundiced by one month. Early jaundice (after 24 hours of age) is generally harmless and physiological in most babies. Breastfed babies are more likely to develop **physiological jaundice** within the first week of life. Physiological jaundice usually appears on day 2, peaks on days 3–5, and resolves by 2 weeks of age. However, pathological causes of jaundice, albeit rare, need to be identified.
- 1.4 **Physiology**

Bilirubin travels in the blood in two ways:

- Either bound to albumin (a protein) when it is called conjugated bilirubin; or free, (not bound) and called unconjugated bilirubin. Some tests measure total bilirubin and do not distinguish between the two forms.
- In newborns unconjugated bilirubin can penetrate the membrane that lies between the brain and the blood (the blood–brain barrier) and is potentially toxic to neural tissue. Entry of unconjugated bilirubin into the brain can cause both short-term and long-term neurological dysfunction (bilirubin encephalopathy). The term **kernicterus** is used to denote the clinical features of acute or chronic bilirubin encephalopathy, as well as the yellow staining in the brain associated with the former. The risk of kernicterus is increased in babies with extremely high bilirubin levels or rapidly rising bilirubin (> 8.5 micromol/litre/hr) or clinical features of acute bilirubin encephalopathy. Kernicterus is also known to occur at lower levels of bilirubin in term babies who have risk factors (such as Rhesus haemolytic disease, sepsis, acidosis or hypoxia), and in preterm babies.

2. CLINICAL RECOGNITION OF NEONATAL JAUNDICE

- Identify babies that are more likely to develop significant hyperbilirubinemia (these should receive an additional visual inspection by a healthcare professional during the first 48 hours of life):
 - gestational age under 38 weeks
 - a previous sibling with neonatal jaundice
 - intending to exclusively breastfeed, where poor feeding is evident or there are concerns or problems with breast-feeding.
 - visible jaundice at 24 hours age
- All babies with visible jaundice should have a bilirubin level check because of the difficulty of estimating severity by the skin colour.
- Identifying jaundice can be particularly tricky in babies with darker skin tones. Consider transcutaneous bilirubinometer measurement before discharge in these babies.
- In all neonates born at 37 or less weeks gestation a bilirubin measurement should be done at 24 hours age. Those 35-37 weeks gestation may have transcutaneous bilirubinometer. Those <35 weeks gestation should have serum bilirubin measurement.
- Health professionals should look for jaundice at every contact with the baby, particularly on day 1 and within the first 72 hours.
- Parents, carers and healthcare professionals should all look for jaundice.
- All parents and carers should be sign-posted to [My baby is yellow / jaundice :: Frimley HealthierTogether \(frimley-healthiertogether.nhs.uk\)](https://www.frimley-healthier-together.nhs.uk/My-baby-is-yellow-jaundice)
- Visually inspect all babies for jaundice: check in bright/natural light, examine the sclerae, gums, and press lightly on the skin to check for jaundice in 'blanched' skin.
- Do not rely on visual inspection alone to estimate the bilirubin level in a baby with jaundice.
- Do not use umbilical cord blood bilirubin level or umbilical cord blood direct antiglobulin test (DAT) (Coombs' test) to predict significant hyperbilirubinaemia.

2.1 How to measure the bilirubin level

2.1.1

- Use serum bilirubin (SBR) in the first 24 hours and in babies with gestational age <35 weeks
- Use transcutaneous bilirubinometer in babies with gestational age ≥ 35 weeks and over 24 hours old
- Re-check transcutaneous values with SBR if level at or above phototherapy line
- If transcutaneous bilirubinometer measurement is >250 micromol/L, measure SBR.
- Use SBR for all monitoring if phototherapy has been used
- Plot the bilirubin on the **appropriate gestation graph** for the gestational age of the baby (follow the link: <https://www.nice.org.uk/guidance/cg98/resources>)

2.1.2 When using the transcutaneous monitor:

- The monitor must only be used on the sternum (more accurate reading in babies that have been exposed to sunlight).
- The monitor must not be used on babies that have had phototherapy (this can bleach the skin and therefore give an inaccurate reading).
- If the baby appears significantly jaundiced and the monitor displays '---', this means the reading is $>340\text{mmol/L}$, and a serum bilirubin test is urgently required.

3. MANAGEMENT AND TREATMENT OF HYPERBILIRUBINAEMIA

- a. Use the bilirubin level to determine the management, i.e., phototherapy or exchange transfusion – see below for further details (see Appendix 1 Threshold table or <https://www.nice.org.uk/guidance/cg98/resources>).

In babies with gestational age of 38 or more weeks *and* more than 24 hours old *and* who are well:

- who have a bilirubin level >50 micromol/L below the phototherapy line, there is no need to repeat bilirubin routinely
- who have a bilirubin level <50 micromol/L below the phototherapy line, repeat bilirubin as:
 - Within 18 hours for babies with a sibling who required phototherapy for neonatal jaundice or those intending to be exclusively breastfed.
 - Otherwise within 24 hours.
- who have a bilirubin level <10 micromol/L below the phototherapy line, repeat in 6-12 hours.

b. PHOTOTHERAPY

3.2.1 Starting Phototherapy

- Only start when bilirubin level **exceeds** the threshold value on the treatment graph.
- Repeat SBR 4-6 hours after starting phototherapy treatment (unless on high intensity phototherapy – see below)
- After which, repeat SBR every 6-12 hours if the SBR is stable or falling.
- Provide information to parents on phototherapy [My baby is yellow / jaundice :: Frimley HealthierTogether \(frimley-healthiertogether.nhs.uk\)](#)

3.2.2 Stopping Phototherapy

- Stop phototherapy once serum bilirubin has fallen to a level at least 50 micromol/litre below the phototherapy threshold (see treatment threshold graphs).
- Check for significant rebound hyperbilirubinaemia (within 10 micromol/L of treatment threshold) ideally 12-18 hours after stopping phototherapy

3.2.3 Types of Phototherapy

Single Light Phototherapy

- Means one overhead unit on maximum brightness (i.e., both buttons pushed in)
- First line for all infants unless they meet criteria for intensified light phototherapy (see below)
- Use conventional 'blue light' phototherapy in babies with a gestational age of 37 weeks.
- Use either fibre optic phototherapy or conventional 'blue light' phototherapy as treatment for significant hyperbilirubinaemia in babies less than 37 weeks.
- Biliblankets should not be used for term infants as first line
- In stable babies allow short breaks (up to 30 minutes) for breastfeeding, nappy changing and cuddles
- Continue lactation/feeding support
- Do not give additional fluids or feeds unless clinically indicated (i.e., dehydrated), if indicated maternal expressed milk is the additional feed of choice
- Monitor hydration by daily weight and assessing wet nappies

Consider continuous intensified phototherapy

- Double phototherapy with LED phototherapy units can be either two overhead light boxes both on maximum brightness or an overhead light and a biliblanket
- Treatment of choice if:
 - SBR is rising rapidly (>8.5 micromol/litre per hour) – this is a risk factor for kernicterus and these babies need admission to NNU.
 - SBR is within 50 micromol/litre of the exchange transfusion threshold (after 72 hours old)
 - SBR remains static/rises within 6 hours of starting single phototherapy
- Discuss whether the baby needs to be admitted to the neonatal unit
- Do not interrupt phototherapy for feeding but continue enteral feeds (and/or intravenous if on the neonatal unit)
- Lactation/feeding support so that breastfeeding can start again when treatment stops
- Repeat SBR 2 hours after initiating multiple phototherapy
- Monitor level every 6 hours thereafter if falling
- If SBR falls to >50 micromol/litre below the exchange transfusion threshold, reduce to single light phototherapy regimen above

3.2.4 General Care of the baby during phototherapy

- Place the baby in a supine position unless other clinical conditions prevent this.
- Ensure treatment is applied to the maximum area of skin.
- Monitor the baby's temperature and full set of observations (to check for deterioration) 4-6hrly and ensure the baby is kept in an environment that will minimise energy expenditure
- Monitor hydration by assessing wet nappies and consider daily weight–phototherapy increases the skin blood flow and skin water loss.
- Eye protection should be placed securely over the eyes to prevent retinal damage whilst the phototherapy unit is turned on. Conjunctival infection and corneal abrasions can go unnoticed if the mask is not removed at regular intervals. Please inform parents of this.

c. INTRAVENOUS IMMUNOGLOBULIN

- Give intravenous immunoglobulin (IVIG) 500mg/kg over 4 hours, as an adjunct to phototherapy, in cases of rhesus or ABO haemolytic disease if SBR rising at >8.5 mmol/hour.
- Follow the 'Neonatal IV infusion formulary' for guidance on prescribing and administration. An IVIG request form must be completed and returned to the appropriate pharmacist at the time of prescribing.
- Give information for parents [My baby is yellow / jaundice :: Frimley HealthierTogether \(frimley-healthiertgether.nhs.uk\)](https://www.frimley-healthier-together.nhs.uk/My-baby-is-yellow-jaundice)
- Adverse effects of IVIG include: fever, allergic reaction, fluid overload and rebound haemolysis. In addition, IVIG is a blood-based product and therefore carries a very small risk of infection transmission. Please inform parents.
- Avoid live vaccines except rotavirus for 3 months following immunoglobulin infusion.

d. EXCHANGE TRANSFUSION

- Undertake a double-volume exchange transfusion to treat babies:
 - whose SBR level is at or above the exchange transfusion threshold (see Appendix 1 Threshold table or <https://www.nice.org.uk/guidance/cg98/resources>)
 - in babies with jaundice and clinical features of acute bilirubin encephalopathy (hypertonia, opisthotonos, fever, recurrent apnoeas, high pitched cry or seizures)
- Give information for parents [My baby is yellow / jaundice :: Frimley HealthierTogether \(frimley-healthiertgether.nhs.uk\)](https://www.frimley-healthier-together.nhs.uk/My-baby-is-yellow-jaundice)
- Adverse effects of exchange transfusion include: blood sugar and electrolyte disturbance, haemodynamic instability, thrombosis, anaemia, thrombocytopenia, necrotising enterocolitis and air emboli. Please inform parents.
- Prepare for exchange if rising rapidly (well in advance of exchange level) as insertion of appropriate central lines and getting appropriate blood can take some time.
- Use **blood which is irradiated and cross-matched against mum**, liaise closely with blood bank. Blood may need to be "blue light" transported if needed within 2 hours.
- For babies coming in from home with SBR above the exchange line, there have been problems requesting urgent blood and then finding that by the time it arrives, the baby has responded to fluids and phototherapy. Blood can be ordered put on 'standby' via blood transfusion pending firm decision. Always inform consultant. (see Appendix 2 "Exchange Transfusion Pathway").
- Please see separate guideline on how to perform an Exchange transfusion.
- Continue intensified phototherapy during and following exchange transfusion.
- Measure SBR within 2 hours of exchange transfusion and manage according to threshold tables (see appendix 1 Threshold table or <https://www.nice.org.uk/guidance/cg98/resources>)

- MRI should be undertaken in a neonate with severe hyperbilirubinemia and signs of acute bilirubin encephalopathy. (Cranial Ultrasound is unable to detect lesion associated with kernicterus). If imaging is normal but there are on-going neurological concerns then a repeat MRI scan at 6 months may be helpful. (BAPM)

4. TIMING OF ONSET OF JAUNDICE

4.1 Babies with jaundice in the first 24 hours of life

- Measure and record the serum bilirubin level urgently and start treatment if indicated as per threshold tables (see Appendix 1 Threshold table or <https://www.nice.org.uk/guidance/cg98/resources>). See above for details on treatment (Phototherapy, Ivlg, exchange transfusion)
- Measure SBR within 4 hours to check rate of rise and then continue to measure the serum bilirubin level every 6 hours (or more frequently if SBR is rising) until the level is both below the treatment line and stable/falling
- Pathological causes need to be excluded:
 - Ensure and urgent medical review
 - Arrange urgent Group & Direct Coombs test (DCT) on baby.
 - Check mother's notes for antibodies, blood group (ABO incompatibility) and ethnicity (G6PD).
 - In addition to haemolysis consider sepsis & intrauterine infections, investigations to consider include:
 - FBC (high or low WCC may suggest sepsis, low platelets may suggest sepsis or congenital infection, Hct <45% may suggest haemolysis)
 - Film (may show evidence of haemolysis)
 - Reticulocyte counts (increased suggests haemolysis)
 - LFTs (may be abnormal in congenital infections)
 - Blood culture, CRP, urine culture, CSF culture (if sepsis suspected)

4.2 Babies with jaundice between day 2-10

- Measure the bilirubin level (as per section 3.1 above) and start treatment if indicated as per threshold tables (see Appendix 1 Threshold table or <https://www.nice.org.uk/guidance/cg98/resources>). See above for details on treatment (Phototherapy, Ivlg, exchange transfusion)
- Consider a pathological cause for jaundice if:
 - -There is no obvious common cause (such as poor feeding, weight loss)
 - -Bilirubin level is slow to respond to phototherapy
 - -Bilirubin level quickly rebounds back onto lights
 - -in these cases, first line investigation would be group & Direct Coombs test (DCT) on baby with clinical review
 - -other tests may include those in the table below (table 1).
 - -consider if there are other clinical features resulting in jaundice: including extravasation of blood (e.g., cephalhaematoma), polycythaemia, delayed gastric transit (including meconium ileus, intestinal stenosis etc)

Dehydration	Weight, electrolytes (U&Es). Check feeding adequately
Sepsis	Clinical examination, FBC, blood cultures, consider LP, consider urine culture
Haemolysis (G6PD/Pyruvate Kinase) or Polycythaemia	Hb & film, G6PD, Group & DCT, recent maternal blood checked for antibodies Venous PCV
Hepatic causes	'Split' bilirubin & liver function tests (LFTs)
Metabolic causes	(eg galactosaemia)

Table 1 – further investigations to consider in jaundice (for prolonged jaundice investigations see below)

4.3 Babies with prolonged jaundice

- Prolonged jaundice is jaundice that is persisting beyond the first 14 days in term infants and beyond 21 days in preterm babies (<37 weeks gestation).
- Prolonged jaundice is generally harmless but can be an indication of serious liver disease.
- Community midwife will check baby's colour again at the 10th day visit. If still jaundiced but improving, ask parents to phone you (the community midwife) on day 14 to confirm that jaundice has resolved.
- **If still yellow at 14 days (term babies) or 21 days (preterm babies), then investigation must be performed as prolonged jaundice pathway.** Please look at Appendix 3 *"Health Visitor and GP pathway for the Investigation of Prolonged Neonatal Jaundice in Primary Care"*.
- The community midwife should make a referral to primary care for well babies with prolonged jaundice. (if unwell please contact paediatrics)
- Causes of Prolonged unconjugated hyperbilirubinaemia:
 - Breast milk jaundice (by exclusion of pathological causes, in healthy breast-fed babies who are gaining weight and have normal stool, urine and examination)
 - Extravasation of blood including cephalhaematoma
 - Haemolysis – (in addition to blood group incompatibility) including RBC enzyme defects (glucose-6-phosphate dehydrogenase deficiency, pyruvate kinase deficiency) and RBC membrane defects (hereditary spherocytosis, infantile pyknocytosis)
 - Familial:
 - common mild dominant (Gilbert)
 - rare severe recessive form (Crigler Najjar).
- There are a number of causes of Conjugated hyperbilirubinaemia: (conjugated bilirubin >25 $\mu\text{mol/l}$ or >15% of total bilirubin) some of which are potential serious, for further investigations see special investigation chart (see Appendix 4).

5. SPECIFIC CASES AND CONSIDERATIONS

5.1 Known maternal antibodies / Babies with jaundice due to haemolysis

- There is usually an antenatal plan in place, please check maternal notes for this.
- If there is no antenatal plan in place then discuss with paediatric registrar (or consultant) who may suggest: (for well, non-hydronic baby) to get urgent cord bloods (SBR, full blood count (FBC), Group & DCT), monitor closely for jaundice (visually +/- SBR) and starting phototherapy if appropriate.
- Please be aware these babies are at high risk of haemolytic disease and may require intensive treatment (including Ivlg and exchange transfusion – see section 4 for further details). Consider wrapping the umbilical cord in saline gauze (in case umbilical lines are required).
- Top-up transfusions are sometimes clinically indicated – note if baby has had previous in utero transfusions (IUTs), **must use irradiated blood**
- Babies with positive DCT should be started on daily folic acid to continue for 3 months and need a repeat FBC arranged at 1-2 weeks (this may need to be repeated until stable).

6. COMMUNITY MIDWIFERY CARE

- If a baby is jaundiced before discharge, but well to go home with no phototherapy requirement, there should be a record in the discharge notes of any observations and TcB or SBR results, feeding pattern, responsiveness, urine output and colour of sclera (baseline for the community midwife). A copy of the **Treatment Threshold Graph** used should be sent out in the discharge pack to the community midwife to enable assessment of whether levels are rising or falling.
- Similarly, community midwives should record feeding pattern, responsiveness, urine output and colour of sclera in the notes for communication between care providers.
- If a baby is well and the TcB is >50 below phototherapy line - do not routinely repeat bilirubin measurement.
- If TcB is < 50 below phototherapy line, then a repeat TcB or serum bilirubin level must be checked
 - Within 18 hours for babies with a sibling who required phototherapy for neonatal jaundice or those intending to be exclusively breastfed where poor feeding is evident or there are on-going feeding challenges.
 - Otherwise within 24 hours.
- If bilirubin on a transcutaneous bilirubinometer is > 250 micro mol/dl arrange for an urgent serum bilirubin check on the postnatal ward at the hospital (WPH, FPH).
- If the baby appears significantly jaundiced and the monitor displays '---', this means the reading is >340mmol/L, and a serum bilirubin test is urgently required.
- Ensure parents/carers have adequate information regarding treatment.
- Provide feeding support and encourage frequent feeding.

7. IMPLEMENTATION PLAN

This guideline will be available on the trust intranet for viewing by Neonatal and Midwifery team.

8. MONITORING COMPLIANCE WITH GUIDELINE

Compliance will be monitored locally in the department. Audit for review of guidelines will be needed regularly to improve the quality of care provided.

REFERENCES

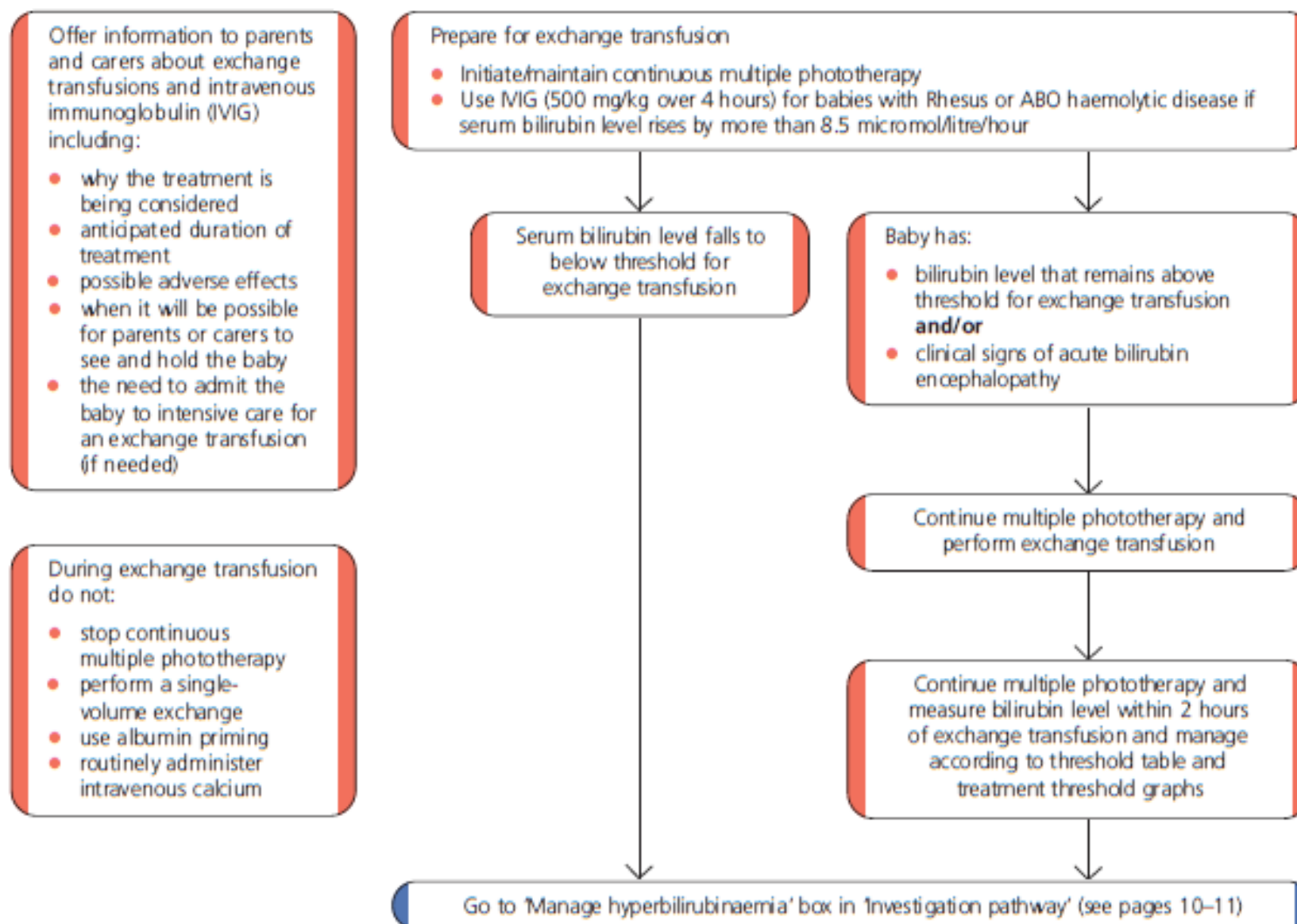
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APPENDIX 1: THRESHOLD TABLE

Consensus-based bilirubin thresholds for management of babies 38 weeks or more gestational age with hyperbilirubinaemia

Age (hours)	Bilirubin measurement (micromol/litre)	
0	> 100	> 100
6	> 125	> 150
12	> 150	> 200
18	> 175	> 250
24	> 200	> 300
30	> 212	> 350
36	> 225	> 400
42	> 237	> 450
48	> 250	> 450
54	> 262	> 450
60	> 275	> 450
66	> 287	> 450
72	> 300	> 450
78	> 312	> 450
84	> 325	> 450
90	> 337	> 450
96+	> 350	> 450
Action	Start phototherapy	Perform an exchange transfusion unless the bilirubin level falls below threshold while the treatment is being prepared

APPENDIX 2: EXCHANGE TRANSFUSION PATHWAY



APPENDIX 3: WEXHAM PARK ONLY. FOR FRIMLEY PARK, FOLLOW LOCAL GUIDANCE ON PROLONGED JAUNDICE.**HEALTH VISITOR and GENERAL PRACTITIONER PATHWAY for the INVESTIGATION of PROLONGED NEONATAL JAUNDICE in PRIMARY CARE**

Prolonged jaundice can present a problem in its management and it is important to know when hospital referral is appropriate. Thorough investigation of prolonged jaundice in the newborn baby is required to avoid delay in the diagnosis and treatment of biliary atresia. However, prolonged jaundice in breast fed babies is very common and over investigation can cause unnecessary anxiety for parents. This pathway aims to streamline care along agreed lines, to avoid missing serious pathology but also to avoid inappropriate interventions for the vast majority of well babies.

BABY PRESENTS WITH PROLONGED JAUNDICE

Greater than 2 weeks of age in >37 week infant &
3 weeks for <37 weeks infant).

Health Visitor (HV) or GP to:

- Assess feeding history and weight gain; stool and urine colour.

Baby WELL & thriving

Urine and stool are normal color
REFER TO THE GP

Baby WELL BUT with dark/yellow
urine or pale stools.

Baby UNWELL or poor weight gain
and or dark urine or pale stools.

General Practitioner (GP) to arrange blood tests and urine dipstix*.

Blood form needs to request **Split Bilirubin (Conjugated and Total Bilirubin)**, FBC, TFTs, Urine MC&S if dipstix suggestive of UTI.

*Phlebotomy & urine dip can be arranged through the Children's Phlebotomy Clinic at Wexham Park Hospital (0300 6154625) or at Frimley Park Hospital via e-referral or phone referral to paediatrics. Call clinic to book (state for "Prolonged Jaundice Screen") and GP to check results on the same day.

GP or HV to refer directly and on the same day by telephone to Paediatrics or Paediatric GP hotline via Frimley Health Foundation Trust switch board 0300 6145000

Unconjugated bilirubinaemia

Bilirubin < 300µmol/l **GP** to reassure parents.
Request repeat split bilirubin if not settling by 4 weeks

If total bilirubin > 300µmol/l
GP to discuss with Paediatrics. Check group & DCT

Mixed or conjugated bilirubinaemia

GP to refer urgently by telephone to Paediatrics if:

Conjugated Bilirubin is elevated
(Normal values): < 25mmol/l

Paediatricians – follow

local Conjugated
Hyperbilirubinaemia
Investigation Guideline for
ongoing management.

APPENDIX 4: CONJUGATED BILIRUBINAEMIA INVESTIGATIONS

NAME..... HOSPITAL No Tel No

**If results show conjugated (>25 µmol & >15% of total), investigate as below
(total = 10 mls blood – prioritise if necessary)**

TEST	Date sent	RESULT
LFTs incl γGT TFTs		
Clotting		
Hep A/B/C		
Toxoplasma Other - parvovirus (& check mum's VDRL result) Rubella CMV Herpes (& maternal HIV result)		
Urine Clinistix & Clintest for reducing substances (kit in SCBU)		
Urine CMV PCR (universal container)		
Abdominal U/S (nil by mouth for 3-4 hours if possible)		
Cortisol 1 x white top		
ImmunoReactiveTrypsin (IRT) for cystic fibrosis: phone Guthrie lab for screening result – 01865~220488)		
Urine amino acids (→lab to freeze urgently)		
α-1-antitrypsin		(+ phenotype if level low)
Gal-1-PUT (liaise with lab in advance)		

- All tests should be discussed with senior staff in biochemistry & virology with clear plan for when results will be available and arrangements with parents.
- It is essential to get all results back by 3-4 weeks of age to allow early referral to King's if biliary atresia suspected.

FULL VERSION CONTROL RECORD

Version:	2.0
Guidelines Lead(s):	C. Ocle-Brown (Consultant Paediatrician)
Contributor(s):	
Lead Director / Chief of Service:	Miss Anne Deans
Library check completed:	2 May 2023
Ratified at:	Cross Site Obstetrics Clinical Governance meeting, 30 July 2024 Paediatric Clinical Governance 17 July 2024.
Date Issued:	2 October 2024
Review Date:	September 2027
Pharmaceutical dosing advice and formulary compliance checked by:	Ruhena Ahmad, Lead Pharmacist for Women and Children, 4 July 2024
Key words:	Jaundice, neonatal jaundice, phototherapy, bilirubin, maternal antibodies

This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	September 2020	D. Alexopoulou	Final	Approved at OGCGC 30 Sept 2020, first cross site version.
2.0	July 2024	C Ocle-Brown	Final	Scheduled review. Approved as above, additional minor amendments by Obstetrics approved by e-governance, October 2024.

Related Documents

None