National Collaborating Centre for Women's and Children's Health

Confirmed Minutes
10h Neonatal Jaundice Guideline Development Group Meeting
Tuesday 17th of November 2009 at NICE

Present:		
GDG members		
	Janet Rennie (JR)	Consultant Neonatologist; GDG Chair
	Donal Manning	Consultant Neonatologist
	Alison Johns (AJ)	Neonatal Nurse
	Debra Teasdale (DT)	Advanced Neonatal Nurse Practitioner
	Farrah Pradhan (FP)	Patient/Carer Representative
	Maria Jenkins (MJ)	Patient/Carer Representative
	Kevin Ives (KI)	Consultant Neonatologist
	Yvonne Benjamin (YB)	Community Midwife
	Karen Ford	Health Visitor
NCC-WCH Technical team		
	Paul Jacklin	Health Economist
	Hugh McGuire (HM)	Research Fellow, NCC-WCH
	Stephen Murphy (SM)	Clinical Director
NICE	Caroline Kier (CK)	NICE Guidelines Commissioning Manager
Apologies:		

1. Welcome, Introductions, Housekeeping, Apologies, and Declarations of Interests
No apologies
HM was to take the minutes

Declarations of Interest: There were no new interests declared by those present at the meeting.
NICE Minutes from the 7th GDG meeting: The minutes (Paper 1b of the meeting papers) needed some amendments before acceptance

Introductions: SM was introduced as the latest Clinical co-director, taking over from Martin Whittle.

DT referred to stakeholder comments saying GDG deserved congratulations for the work they have done.

JR highlighted main themes she had picked up in comments; including CLDF Foundation comments on urine colour/split bilirubin, the fact that bilirubin is beneficial to the baby's health, sunlight as an intervention, and whether to include gums in a visual inspection

Point 1a- Several stakeholders suggested that recommendations on urine colour, chalky stools be changed and agreement was met to keep statement on pale chalky stools in guideline.

Point 1b KI spoke about the false reassurance of split bilirubin before prolonged jaundice. The GDG discussed whether to use conjugated bilirubin as either percentage of total serum bilirubin or a defined level ie 20 micromol/L as a sign of conjugated bilirubin and decided that percentages were potentially misleading and that a defined level should be used.

2. Frequency of measurements: The GDG re-examined these based on conflicting comments from stakeholders and agreed to keep to 6-12 hours. It was noted by JR that 6 hourly tested were supported by the Royal College of Pathologists.

3. Fluid delivery during phototherapy: Multiple stakeholder comments were received on this issue and were considered. KF, DT, YB considered that interruption of 30 minutes were sufficient time for breastfeeding or other feeding. It was recognised that this would be a significant change in practice in most postnatal wards. The GDG considered that 30 minutes in every 3-4 hours should not be taken literally and could be 3 x 10 mins, 2 x 15 minutes, 1 x 30 minutes etc.

During multiple phototherapy- no drip would be needed as expressed breast milk could be fed via or bottle and IV would only be used in circumstances where external feeds are not tolerated.

4. IVIG: DM raised the issue of IVIG being used in cases of 'anticipated' haemolysis. GDG did not want to revisit the issue of prophylactic treatments but decided that ABO haemolysis should be added to rhesus haemolysis as cases where IVIG should be indicated.

5. Rebound Jaundice. JR repeated the stakeholder comments on whether checking for rebound jaundice after 12 – 18 hours would keep babies in hospital unnecessarily. HM noted that as GDG had recommended stopping phototherapy after one 50 micromol/L drop below age appropriate threshold the extra 6 hours would provide an extra safety net. The GDG considered a minor modification to recommendation on double phototherapy to include going back to single phototherapy on care pathway and recommendations.

6. G-6-PD levels: JR noted that multiple stakeholders had requested a list of ethnic groups in who G-6-PD testing was indicated and pointed out that the list is changing over time and a definite list would be nearly always out of date. HM agreed to check if WHO had a constantly updated list that could by hyperlinked to.

7. Bilirubin should this be serum or circulating bilirubin: Stakeholder comments raised the issue and HM reported on response from pathologist which was added to response to stakeholder comment. The GDG decided to add serum bilirubin to glossary to take account of fact of difference between serum or circulating bilirubin

Other issues:
PJ gave an overview on health economic comments: Health economic evaluation of different phototherapy devices was not done because cost of phototherapy is immaterial when compared to cost of admission. PJ agreed to look at health economics of IVIG and exchange transfusions.

KI highlighted the fact that while the while Bilirubin-Albumin ratio may not be useful, knowledge of Albumin levels may be and decided to make a minor amendment to translation (after bit on Bart trial "the GDG feels that awareness of low Albumin levels ….. ") but that no change to recs was warranted.

JR re-examined treatment algorithm and GDG were happy to clarify some points as follow:

Treatment Algorithm
- give patient information
- use eye protection
- continue feed

check serum bilirubin after 6 hours and then 6-8 hourly

TREATMENT PATHWAY

Phototherapy algorithm was deemed to be ok. The exchange transfusion would need amendments by adding 'acute neurological signs' to indications for an exchange transfusion as this is good clinical practice. CK agreed to check with NICE to see if this would be allowed.

New studies to be added:
Check data on JM-103 (newly published study) and another newly published on risk factors by Maisels

Close

Signed:..... Janet McKenzie ..... Date: 31.3.10

Janet Rennie, GDG chair