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

Unconfirmed minutes
7th Neonatal Jaundice Guideline Development Group Meeting
Part 1 –Tuesday the 7th of April 2009 (10am – 4pm) at the RCOG
Part 2 – Wednesday the 8th of April 2009 (9.30am – 3.30pm) at the RCOG

Present:		
GDG members		
	Janet Rennie (JR)	Consultant Neonatologist; GDG Chair
	Christiana Aride (CA)	General Practitioner
	Alison Johns (AJ)	Neonatal Nurse
	Debra Teasdale (DT) (day 1)	Advanced Neonatal Nurse Practitioner
	Farrah Pradhan (FP)	Patient/Carer Representative
	Donal Manning (DM)	Consultant Paediatrician
	Kevin Ives (KI)	Consultant Neonatologist
	Karen Ford (KF)	Senior Lecturer. Health Visitor
	Yvonne Benjamin (YB)	Community Midwife
NCC-WCH Technical team		
	Carolina Ortega (CO)	Work Programme Coordinator, NCC-WCH
	Itrat Iqbal (II)	Health Economist, NCC-WCH
	Rajesh Khanna (RK)	Senior Research Fellow, NCC-WCH
	Hugh McGuire (HM)	Research Fellow, NCC-WCH
Apologies:	Martin Whittle (MW)	Clinical Co-Director, NCC- WCH
	Maria Jenkins (MJ)	Patient/Carer Representative
	Caroline Keir (CK)	NICE Guidelines Commissioning Manager
	Jeffrey Barron (JBar)	Clinical Pathologist

Part 1 – Tuesday the 7th of April 2009.

1. HM gave a presentation on phototherapy. HM explained to the GDG that he divided Chapter 5 (Treatment) between pre-term low weight babies (5.1.2) and term babies. HM explained the different studies revisited and the changes made. The GDG commented on the results of the studies (which excluded Rhesus' disease but included ABO deficiency). The GDG discussed the changes made to the evidence statement. The GDG discussed 'aggressive phototherapy' and the lack of evidence. Intensive phototherapy in pre-term babies reduced the necessity of further treatment/ occurrence of further complications (New England Journal). HM said this could go on the GDG translation. KI said the definition of term and pre-term should be defined in the glossary. RK told the GDG they could have a separate set of recommendations for term and pre-term babies. The GDG read recommendation 5.1.11 and discussed it.

2. The GDG commented on the recommendations and edited them according to the new evidence statement. KI suggested adding breaks for 'feeding and cuddles' to the phototherapy recommendation. The GDG agreed and it was changed accordingly. The GDG discussed aspects of conventional phototherapy including eye cover, which eye cover to use, etc. The GDG discussed conventional phototherapy for term babies including good practice points accruing to the GDGs practice. The GDG also discussed temperature in terms of environment and agreed to add 'a thermo-neutral environment' – they agreed that the meaning of it will have to be defined in the Glossary. The GDG discuss whether to

anything higher than that is physiological jaundice. The rising rate of hyperbil on the graph changes according to the number of weeks (pre-terms). The GDG were concerned about midwives not being able to re-visit the mother at 6 hrs. The GDG agreed that the dotted line on the graph should indicate a TCB reading in to be taken every 6 hrs. The GDG reconsidered the table for term babies:

Hours		Phototherapy	Intensive treatment: consider ET if no response
25-48		250	350
49-72		300	400
>72		350	450

The GDG discussed these numbers at length. JR revised the kernicterus registry and RK told the GDG to write an introductory paragraph to explain tables. The GDG discussed levels for babies with a GA = 37-36 weeks and drafted a table.

For babies < 24 hrs who have visible jaundice
All babies with a raising rate of 8.5 micromol/lt/hr (which suggests haemolysis) should be considered for intensive treatment.

12. Group discussion on q 13. What information and support should be given to parents/carers of babies with neonatal hyperbilirubinaemia?

a) What is Jaundice/ What to look for? : An information sheet for parents (at time of birth) as they leave the hospital. It should include things such as:
   - Jaundice is normal/ common, look out for it (but it may need treatment).
   - What is jaundice
   - GDG discussed yellow alert leaflets & taking them as a starting point. Parent information at Antenatal clinic at 36 weeks (before birth).
   - Warning signs for bilirubin encephalopathy: drowsiness, change in sleeping and feeding patterns, change in colour.
   - PDF model leaflet in full guideline
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Lunch break.

13. RK presented items 8 and revisited the evidence for recognition. The presentation included:
- Clinical/ visual inspection.
- RK revised table. Information assessing the severity of Jaundice.

The GDG discussed the presentation in light of the Karen paper on negative predictive value. If babies don't have clinical visible jaundice in the first two days they will be unlikely to enter the risk zone. Clinical assessment in ruling out is good. The GDG discussed this in terms of the Care Pathway.

14. JR presented item 19 to the GDG:
- Change into hours from days.
- All babies go into the care pathway.
- JR presented the distributed pathway to the GDG.
- Last line of pathway: interpret the result according to our charts.
- GDG discussed whether they use hrs or days – agreed to stick to hours.
- GDG discussed whether babies should have a TCB on discharge.
- At 48 hrs an assessment is done, not always including a TCB.
- Babies with no risk factors.