A prescription-screening tool to optimise pharmacotherapy for hospitalised neonates


**Main statement**

**Complementary informations**

**Grade of recommendations:**

**References**

---

**Table of GOR scale**

<table>
<thead>
<tr>
<th>Levels of evidence</th>
<th>Grades of recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1++</td>
<td>High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias</td>
</tr>
<tr>
<td>1+</td>
<td>Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias</td>
</tr>
<tr>
<td>1-</td>
<td>Meta-analyses, systematic reviews or RCTs, or RCTs with a high risk of bias</td>
</tr>
<tr>
<td>2++</td>
<td>High quality systematic reviews of case-control or cohort studies or High quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal</td>
</tr>
<tr>
<td>2+</td>
<td>Well conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal</td>
</tr>
<tr>
<td>2-</td>
<td>Case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal</td>
</tr>
<tr>
<td>3</td>
<td>Non-analytic studies, eg case reports, case series</td>
</tr>
<tr>
<td>4</td>
<td>Expert opinion</td>
</tr>
</tbody>
</table>

**GOR scale**

- A: At least one meta-analysis, systematic review, or RCT rated as 1++ and directly applicable to the target population OR A systematic review of RCTs or a body of evidence
- B: A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results OR Extrapolated evidence from studies rated as 1++ or 1+
- C: A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results OR Extrapolated evidence from studies rated as 2++
- D: Evidence level 3 or 4 OR

---

**Item design**

**Start / stop / other**

**Main statement**

**Complementary informations**

**Grade of recommendations:**

**References**

---

**Age/weight**

**Category/Subcategory**

**Drug**

---

**HUG**

Hôpitaux Universitaires
Genève
<table>
<thead>
<tr>
<th>No.</th>
<th>Main statement</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>BASIC MANAGEMENT</strong></td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td><strong>Body Care</strong></td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>1. Do not use routinely topical ointments in preterm neonates.</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>2. Stop the use of antiseptics for the daily care of the uncomplicated umbilical cord in healthy hospitalized term neonates.</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td><strong>Vaccination</strong></td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>3. Administer a dose of DTPa-IPV/Hib ± HBV and of pneumococcal vaccine at 60, 90 and 120 days of postnatal life to all hospitalized preterm neonates.</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>4. Recommend BCG vaccine at discharge to neonates at high risk of tuberculosis exposure in the first year of life.</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>5. Check / administer Pertussis vaccination to close contacts of neonates.</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>6. Check status and recommend or administer vaccination to close contacts of neonates.</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td><strong>Parenteral nutrition</strong></td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>7. Start parenteral nutrition shortly after birth in all preterm neonates when it is clear that enteral feeds will not be tolerated soon.</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>8. Start reducing the percentage of parenteral nutrition as quickly as possible by the introduction of enteral nutrition until enteral nutrition finally replaces completely PN in order to minimise any side-effects from exposure to PN.</td>
<td>4</td>
</tr>
<tr>
<td>13</td>
<td>9. Start continuous parenteral glucose administration in preterm infants needing parenteral nutrition.</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>10. Start amino acid supply in the first day of life in preterm infant needing parenteral nutrition.</td>
<td>6</td>
</tr>
<tr>
<td>15</td>
<td>11. Start continuous lipid emulsion infusion within the first 24-48 hours of life in preterm infant needing parenteral nutrition,</td>
<td>7</td>
</tr>
<tr>
<td>16</td>
<td>12. Do not administer parenteral lipid emulsion at a dose higher than 3-4 g/kg/day in neonates.</td>
<td>7</td>
</tr>
<tr>
<td>17</td>
<td>13. Check that a sufficient quantity of linoleic acid is administered in all neonates on parenteral nutrition.</td>
<td>8</td>
</tr>
<tr>
<td>18</td>
<td>14. Start electrolytes supplementation with parenteral nutrition after onset of diuresis.</td>
<td>8</td>
</tr>
<tr>
<td>19</td>
<td>15. Start vitamins and trace elements supplementation in neonates receiving parenteral nutrition.</td>
<td>9</td>
</tr>
<tr>
<td>20</td>
<td>16. Start vitamin D supplementation from the first days of life in all neonates.</td>
<td>9</td>
</tr>
<tr>
<td>21</td>
<td><strong>CARDIOLOGY</strong></td>
<td>10</td>
</tr>
<tr>
<td>22</td>
<td><strong>Congenital Heart Disease</strong></td>
<td>10</td>
</tr>
<tr>
<td>23</td>
<td>17. Start prostaglandin E1 (alprostadil) as an initial continuous intravenous infusion at 0.01 mcg/kg/min, until a definitive diagnosis is made in an infant suspected of having ductus-dependant heart disease.</td>
<td>10</td>
</tr>
<tr>
<td>24</td>
<td>18. Reassess the indication of prostaglandin E1 (PGE1) treatment.</td>
<td>10</td>
</tr>
<tr>
<td>25</td>
<td>19. Stop ibuprofen, indomethacin and paracetamol in patients with duct dependent congenital heart disease.</td>
<td>10</td>
</tr>
<tr>
<td>26</td>
<td><strong>Patent Ductus Arteriosus (PDA)</strong></td>
<td>11</td>
</tr>
<tr>
<td>27</td>
<td>20. Consider pharmacological closure of confirmed patent ductus arteriosus (PDA) in preterm neonates after 2 weeks of life, with ibuprofen as first-line treatment.</td>
<td>11</td>
</tr>
<tr>
<td>28</td>
<td>21. Reassess the indication of ibuprofen, indomethacin and paracetamol in preterm neonates &lt;2 weeks of life with confirmed or unconfirmed patent ductus arteriosus (PDA).</td>
<td>11</td>
</tr>
<tr>
<td>29</td>
<td>22. Reassess the indication of ibuprofen, indomethacin and paracetamol in term neonates with patent ductus arteriosus (PDA).</td>
<td>12</td>
</tr>
<tr>
<td>30</td>
<td>23. Do not use paracetamol as first-line treatment for patent ductus arteriosus (PDA) closure. Consider a switch to ibuprofen.</td>
<td>12</td>
</tr>
<tr>
<td>31</td>
<td><strong>Hypotension</strong></td>
<td>13</td>
</tr>
<tr>
<td>32</td>
<td>24. Do not use volume expansion as first line treatment in VLBW infants (BW &lt;1500g) with hypotension.</td>
<td>13</td>
</tr>
<tr>
<td>33</td>
<td>25. Consider a conservative approach (permissive hypotension) for the management of VLBW infants (BW &lt;1500g) if the clinical examination is satisfactory in the face of apparent hypotension</td>
<td>13</td>
</tr>
<tr>
<td>34</td>
<td><strong>HEMATOLOGY</strong></td>
<td>14</td>
</tr>
<tr>
<td>35</td>
<td><strong>Anemia</strong></td>
<td>14</td>
</tr>
<tr>
<td>36</td>
<td>26. Do not use routinely erythropoietin to limit exposure to blood transfusions in preterm neonates. The indication of treatment should be reassessed.</td>
<td>14</td>
</tr>
<tr>
<td>37</td>
<td>27. Start iron supplement of 2-3 mg/kg/day in all preterm infants fed human milk once full oral feeds have been achieved.</td>
<td>14</td>
</tr>
<tr>
<td>38</td>
<td><strong>Coagulation disorders</strong></td>
<td>15</td>
</tr>
<tr>
<td>39</td>
<td>28. Start oral Vitamin K in neonates breastfed by a mother treated with phenprocoumone.</td>
<td>15</td>
</tr>
<tr>
<td>40</td>
<td>29. Check in all neonates that a complete Vitamin K prophylaxis has been given at birth.</td>
<td>15</td>
</tr>
<tr>
<td>41</td>
<td><strong>Thrombocytopenia and Platelet Dysfunction</strong></td>
<td>16</td>
</tr>
<tr>
<td>42</td>
<td>30. Consider platelets transfusion even in the absence of bleeding in all neonates with a platelet count of &lt;30x10^9/L.</td>
<td>16</td>
</tr>
<tr>
<td>43</td>
<td>31. Consider platelets transfusion in neonates with a platelet count of 30-49x10^9/L and minor bleeding or those at risk for major bleeding.</td>
<td>17</td>
</tr>
<tr>
<td>44</td>
<td>32. Consider platelets transfusion in neonates with a platelet count of 50-99x10^9/L only if bleeding is present.</td>
<td>17</td>
</tr>
<tr>
<td>45</td>
<td>33. Do not transfuse neonates with mild thrombocytopenia (platelet count 100-150x10^9/L) even if bleeding is present.</td>
<td>18</td>
</tr>
<tr>
<td>46</td>
<td>34. Start intravenous immunoglobulin (IVIG) only in case of severe thrombocytopenia (platelet count of &lt;50x10^9/L) or if bleeding persists despite compatible platelets transfusion or in combination with unmatched platelets transfusion in neonates with neonatal allo-immune thrombocytopenia (NAT).</td>
<td>18</td>
</tr>
<tr>
<td>47</td>
<td>35. Start intravenous immunoglobulin (IVIG) as first line treatment in neonates with neonatal auto-immune thrombocytopenia and born to mothers who have idiopathic thrombocytopenic purpura (ITP), when platelet count is of &lt;30x10^9/L or clinical bleeding is present.</td>
<td>19</td>
</tr>
<tr>
<td>48</td>
<td><strong>Vasospasms and Thromboembolism</strong></td>
<td>20</td>
</tr>
<tr>
<td>49</td>
<td>36. Start unfractionned heparin or low molecular weight heparin in neonates with a first event venous thromboembolism for at least 5 days.</td>
<td>20</td>
</tr>
<tr>
<td>50</td>
<td>37. Start alteplase or urokinase only in case of major vessel occlusion causing critical compromise of organs or limbs in infants with venous thromboembolism.</td>
<td>20</td>
</tr>
<tr>
<td>N°</td>
<td>Main statement</td>
<td>Page</td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td><strong>PNEUMOLOGY</strong></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Do not use routine supplemental oxygen use in infants with spontaneous pneumothorax.</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td><strong>Apnea of Prematurity</strong></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Start caffeine citrate in patients with apnea of prematurity (loading dose 20 mg/kg; maintenance dose 5mg/kg/day). Dose may be increased to 10 mg/kg/day if apnea persists.</td>
<td>22</td>
</tr>
<tr>
<td>40</td>
<td>Reassess the need for caffeine citrate treatment.</td>
<td>23</td>
</tr>
<tr>
<td>41</td>
<td>Reassess the indication of anti-gastroesophageal reflux therapy in neonates with apnea.</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td><strong>Bronchopulmonary Dysplasia (BPD)</strong></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Do not use dexamethasone in the prevention or the treatment of bronchopulmonary dysplasia.</td>
<td>24</td>
</tr>
<tr>
<td>43</td>
<td>Do not use loop diuretics for prevention of BPD in preterm neonates.</td>
<td>25</td>
</tr>
<tr>
<td>44</td>
<td>Do not use thiazide diuretics for prevention of BPD in preterm neonates. Use them judiciously for treatment of BPD in preterm neonates.</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td><strong>Respiratory Distress Syndrome (= Hyaline Membrane Disease)</strong></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Start surfactant therapy in infants born &lt;26 weeks of gestational age who need FiO2 &gt;0.30.</td>
<td>26</td>
</tr>
<tr>
<td>46</td>
<td>Start surfactant therapy in infants born ≥26 weeks of gestational age who need FiO2 &gt;0.40.</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td><strong>Meconium Aspiration Syndrome</strong></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Consider inhaled nitric oxide (INO) in neonates with hypoxic respiratory failure due to MAS.</td>
<td>27</td>
</tr>
<tr>
<td>48</td>
<td>Reassess the indication for antibiotics in patients with MAS alone.</td>
<td>27</td>
</tr>
<tr>
<td>49</td>
<td>Administer a bolus instillation of surfactant in intubated infants with MAS requiring more than 50% oxygen.</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td><strong>Persistent Pulmonary Hypertension of the Newborn (PPHN)</strong></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Start inhaled nitric oxide (INO) in neonates who have severe PPHN.</td>
<td>28</td>
</tr>
<tr>
<td>51</td>
<td>Do not use sildenafil as initial therapy for PPHN.</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td><strong>NEPHROLOGY</strong></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Do not use nephrotoxic drugs in neonates if possible, especially in preterm infants.</td>
<td>29</td>
</tr>
<tr>
<td>53</td>
<td>Stop all nephrotoxic drugs when possible in neonates with AKI (stage 1-3).</td>
<td>30</td>
</tr>
<tr>
<td>54</td>
<td>Consider dosage adjustment for drugs highly excreted by renal elimination in neonates with AKI (stage 1-3). When needed, refer to a specialist.</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td><strong>GASTROENTEROLOGY</strong></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Decrease or stop intravenous soybean-based lipid emulsion in neonates with marked progressive cholestasis associated with parenteral nutrition.</td>
<td>31</td>
</tr>
<tr>
<td>56</td>
<td>Administer adequate protein intake of 2 to 3 g/kg/day to neonates with direct hyperbilirubinemia.</td>
<td>32</td>
</tr>
<tr>
<td>57</td>
<td>Start fat-soluble vitamins (ADEFK) in neonates with cholestasis.</td>
<td>32</td>
</tr>
<tr>
<td>58</td>
<td>Consider ursodeoxycholic acid (UDCA) in neonate with direct hyperbilirubinemia.</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td><strong>Indirect hyperbilirubinemia (Unconjugated Hyperbilirubinemia)</strong></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Administer intravenous immunoglobulin (IVIG) to neonates with a positive direct Coombs test and severe hyperbilirubinemia, or to those progressing to severe hyperbilirubinemia despite initial treatment.</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td><strong>Necrotizing Enterocolitis (NEC)</strong></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Start probiotics in preterm neonates at high risk of developing NEC.</td>
<td>35</td>
</tr>
<tr>
<td>61</td>
<td>Stop all enteral medications in neonates suspected to have NEC.</td>
<td>36</td>
</tr>
<tr>
<td>62</td>
<td>Do not use enteral antibiotics for the prevention of NEC.</td>
<td>36</td>
</tr>
<tr>
<td>63</td>
<td>Start broad spectrum antibiotic promptly after blood cultures have been drawn in neonates with any stage of NEC.</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td><strong>Gastrointestinal Bleeding from the Upper Tract</strong></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Check that a Vitamin K prophylaxis was administered postdelivery in neonates with upper gastro-intestinal bleeding, to guide diagnostic.</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td><strong>Gastroesophageal Reflux</strong></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Consider proton pump inhibitors or H2-blockers only in neonates with severe cases of acid gastroesophageal reflux disease (GERD), when non-pharmacological measures (including milk thickeners) have failed.</td>
<td>38</td>
</tr>
<tr>
<td>66</td>
<td>Do not use metoclopramide, domperidone or erythromycin to treat gastroesophageal reflux or gastroesophageal reflux disease.</td>
<td>39</td>
</tr>
<tr>
<td>N°</td>
<td>Main statement</td>
<td>Page</td>
</tr>
<tr>
<td>----</td>
<td>----------------</td>
<td>------</td>
</tr>
<tr>
<td><strong>NEUROLOGY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Seizures</strong></td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>67</td>
<td>Start phenobarbital as the first line agent in neonates with either EEG diagnosed or clinically apparent seizures when prolonged or frequent.</td>
<td>40</td>
</tr>
<tr>
<td>68</td>
<td>Consider phenytoin or a benzodiazepine or lidocaine in neonates with persistent seizures, despite adequate phenobarbital treatment.</td>
<td>41</td>
</tr>
<tr>
<td>69</td>
<td>Stop antiepileptic drugs if seizure-free for &gt;72 hours in neonates with normal neurological examination and/or normal electroencephalography.</td>
<td>41</td>
</tr>
<tr>
<td>70</td>
<td>Consider pyridoxine only in neonates with recurrent seizures with no obvious cause.</td>
<td>41</td>
</tr>
<tr>
<td><strong>PAIN, SEDATION &amp; NEONATAL ABSTINENCE SYNDROME</strong></td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>Pain, Analgesia &amp; Sedation</td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>71</td>
<td>Start pain management in neonates with non-pharmacological techniques (incl. Sucrose) if appropriate.</td>
<td>42</td>
</tr>
<tr>
<td>72</td>
<td>Start paracetamol in neonates who are still in pain despite adequate non-pharmacological interventions.</td>
<td>42</td>
</tr>
<tr>
<td>73</td>
<td>Do not use nonsteroidal antiinflammatory agents (NSAID) as analgesics.</td>
<td>43</td>
</tr>
<tr>
<td>74</td>
<td>Start morphine as first line treatment for pain relief in neonates who are still in pain despite adequate non-pharmacological techniques and paracetamol treatment.</td>
<td>43</td>
</tr>
<tr>
<td>75</td>
<td>Start opioids as first line treatment for postoperative analgesia, and use them as long as pain assessment scales deem necessary.</td>
<td>44</td>
</tr>
<tr>
<td>76</td>
<td>Reassess the indication of morphine or fentanyl in chronically ventilated preterm neonates without pain.</td>
<td>45</td>
</tr>
<tr>
<td>77</td>
<td>Do not use ketamine treatment for routine management of pain.</td>
<td>45</td>
</tr>
<tr>
<td>Neonatal Abstinence Syndrome (NAS)</td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>78</td>
<td>Consider non-pharmacological interventions for the initial management of all infants suspected of having or at risk of developing NAS. This may mitigate the need for medication.</td>
<td>46</td>
</tr>
<tr>
<td>79</td>
<td>Start morphine as the first line pharmacological treatment for NAS when opioids are used by the mother and supportive measures failed.</td>
<td>46</td>
</tr>
<tr>
<td>80</td>
<td>Start weaning of morphine as soon as Modified Finnegan scores are &lt;8 for 24 to 48 hours in neonates with NAS.</td>
<td>47</td>
</tr>
<tr>
<td>81</td>
<td>Do not use morphine in neonates with NAS when the drugs used by the mother are non-opioids.</td>
<td>47</td>
</tr>
<tr>
<td><strong>INFECTIOLOGY</strong></td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>Meningitis</td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>82</td>
<td>Start empirical antibiotic treatment with high dose amoxicilline and gentamicin in neonates with diagnosed or strongly suspected meningitis.</td>
<td>48</td>
</tr>
<tr>
<td>83</td>
<td>Check results of cerebro-spinal fluid (CSF) culture as soon as they are available in order to reassess the need for treatment or the choice of antibiotics in neonates with suspected meningitis treated with empirical antibiotics.</td>
<td>48</td>
</tr>
<tr>
<td>84</td>
<td>Do not use corticosteroids for the treatment of neonates with suspected or confirmed bacterial meningitis. Reassess the corticosteroid indication.</td>
<td>49</td>
</tr>
<tr>
<td>Sepsis</td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>85</td>
<td>Do not use empirical antibiotic therapy for asymptomatic neonates with a single risk factor of infection (incl. mother with suspected choorioamnionitis or unexplained premature delivery).</td>
<td>51</td>
</tr>
<tr>
<td>86</td>
<td>Start empirical antibiotic treatment after blood cultures have been drawn in all newborn infants with suggestive signs of neonatal infection.</td>
<td>51</td>
</tr>
<tr>
<td>87</td>
<td>Reassess the need for antibiotics after 48 hours in neonates treated empirically with antibiotics for suspected sepsis.</td>
<td>52</td>
</tr>
<tr>
<td>88</td>
<td>Do not use cephalosporins as first-line treatment in infant with suspected neonatal infection, because of the high risk of developing resistance. Use is restricted to special cases.</td>
<td>52</td>
</tr>
<tr>
<td>89</td>
<td>Do not use intravenous immunoglobulin in the treatment of suspected or proven neonatal sepsis.</td>
<td>53</td>
</tr>
<tr>
<td>90</td>
<td>Do not use Vancomycin as prophylaxis against sepsis in preterm neonates.</td>
<td>53</td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td>54</td>
</tr>
<tr>
<td>91</td>
<td>Administer an initial dose of hepatitis-B vaccine within 12 hours of birth in infants born to HBsAg-positive mothers, including infants weighing &lt;2000g. Administer Hepatitis-B immune globulins (HBIG) 200 IU concurrently but at a different anatomic site.</td>
<td>54</td>
</tr>
<tr>
<td>92</td>
<td>Do not use early hepatitis-B vaccine in infants born to mothers whose HBsAg and HBeAg status is negative but with positive anti-HBs status (prior infection or at risk of infection).</td>
<td>54</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus (HIV)</td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>93</td>
<td>Start HIV prophylaxis with zidovudine as close to birth as possible for at least 4 weeks or consider tritherapy in neonates born to HIV-infected mothers who did not follow proper antenatal treatment or whose viremia are detectable.</td>
<td>55</td>
</tr>
<tr>
<td>94</td>
<td>Start tritherapy immediately in the neonate aged &lt;72 hr if the mother is diagnosed postpartum with HIV infection.</td>
<td>55</td>
</tr>
</tbody>
</table>
Respiratory Syncytial Virus (RSV)

93 Start respiratory syncytial virus prophylaxis with palivizumab in neonates with severe bronchopulmonary dysplasia (BPD). 56
96 Start respiratory syncytial virus prophylaxis with palivizumab in neonates with haemodynamically significant congenital heart disease AND other associated risk factors. 56
97 Do not use respiratory syncytial virus prophylaxis with palivizumab routinely in preterm neonates. 57
98 Do not use palivizumab for the treatment of respiratory syncytial virus (RSV) infection. Stop the treatment, even if it was given before the infection. 57

Toxoplasmosis

99 Administer a combination of pyrimethamine-sulfadiazine-folinic acid during the first year of life to neonates in whom a diagnosis of congenital toxoplasmosis is confirmed or probable. 58
100 Do not use spiramycin in neonates. Stop treatment and screen for potential QT interval prolongation. 58

Cytomegalovirus (CMV)

101 Start antiviral treatment as soon as virologic testing is confirmed and within the first 30 days of life in symptomatic cytomegalovirus (CMV) infected newborns with central nervous system involvement or if life-threatening. 59
103 Start a topical antiviral treatment in combination with aciclovir IV in neonates with Herpes Simplex Virus (HSV) disease with ocular involvement. 62

Varicella-Zoster Virus (VZV)

105 Start Varicella-Zoster Immune Globulin (VZIG) 125IU IM as soon as exposure is known and within a 72 hour period, independent of maternal history of varicella, in neonates born at <28 weeks of gestational age or who weighed <1000g at birth who have been significantly exposed to Varicella-Zoster Virus (VZV). 63
106 Start Varicella-Zoster Immune Globulin (VZIG) 125IU IM in neonates ≥28w GA or ≥1000g BW who have been significantly exposed postnatally to Varicella-Zoster Virus (VZV), only if born to mother who has no or unknown history of varicella. 63
107 Start Varicella-Zoster Immune Globulin (VZIG) 125IU IM as soon as possible, after birth or with onset of maternal illness, in term or late preterm neonates whose mother had varicella disease 5 days prior to or 2 days after delivery. 64
108 Start aciclovir IV in neonates who develop systemic symptoms or severe cutaneous Varicella-Zoster disease, or who are at high risk of infection. 64
109 Stop Varicella-Zoster Immunoglobulin (VZIG) if neonatal chickenpox has developed. 65

Chlamydia

110 Do not use prophylactic antibiotic treatment in neonates at high risk of chlamydial infection (born to mothers who have untreated chlamydia). 66
111 Start erythromycin orally for 14 days in neonates with chlamydial conjunctivitis or with suspected or confirmed chlamydial pneumonia. 66
112 Start azithromycin as second line treatment when erythromycin is not available in neonates with chlamydial conjunctivitis or with suspected or confirmed chlamydial pneumonia. 67
113 Stop topical antibiotics for the treatment of chlamydial conjunctivitis in neonates. 67

Gonorrhea

114 Administer 1 dose of ceftriaxone IV or IM in all neonates born to mothers who have untreated gonorrhea. 68
115 Administer 1 dose of ceftriaxone IV or IM in neonates with suspected or confirmed gonococcal opthalmia neonatorum or other localized gonococcal infection. 68
116 Stop topical antibiotics in neonates with suspected or confirmed gonococcal opthalmia neonatorum. 69
117 Start ceftriaxone IV or IM in neonates with disseminated gonococcal infection. 69

Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections

118 Start vancomycin IV until bacteremia is excluded for localized Methicillin-resistant Staphylococcus aureus (MRSA) disease in preterm or very low-birthweight neonates or in more-extensive forms of the disease involving multiple sites in full-term neonates. 70

Syphilis

119 Administer benzylpenicillin G IV, OR procaine penicillin to neonates with confirmed or presumed congenital syphilis, or born to syphilis infected mothers who have not been treated with penicillin at least four weeks prior delivery. 71
120 Administer 1 dose of benzathine penicillin G IM in neonates with normal examination, born to syphilis infected mothers who have been adequately treated during pregnancy more than 4 weeks prior to delivery. 72

Ureaplasma Urealyticum Infection

121 Reassess the use of macrolides or other antibiotics for the treatment of Ureaplasma urealyticum in neonates. 73
<table>
<thead>
<tr>
<th>No.</th>
<th>Main statement</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>122</td>
<td>Start empiric antibiotics after urine samples and cultures are collected in neonates with fever when urinary tract infection is suspected.</td>
<td>74</td>
</tr>
<tr>
<td>123</td>
<td>Consider antibiotic prophylaxis after an urinary tract infection (UTI) only in neonates with grade IV-V vesico-ureteric reflux.</td>
<td>75</td>
</tr>
<tr>
<td>124</td>
<td>Start azithromycin oral daily for 5 days in neonates with suspected or confirmed pertussis infection, or in those in close contact with confirmed and contagious cases of pertussis.</td>
<td>76</td>
</tr>
<tr>
<td>125</td>
<td>Start isoniazid prophylaxis orally in neonates born to mothers with tuberculosis (TB), or those in close contact with people with smear-positive pulmonary or laryngeal TB who have not had at least 2 weeks of anti-tuberculosis treatment.</td>
<td>77</td>
</tr>
<tr>
<td>126</td>
<td>Start anti-tuberculosis treatment in neonates with congenital tuberculosis or postnatal tuberculosis primary pulmonary disease.</td>
<td>77</td>
</tr>
<tr>
<td>127</td>
<td>Administer calcium, phosphate and vitamin D in preterm infants &lt;32 weeks of gestational age or &lt;1500g or infants at risk of metabolic bone disorders.</td>
<td>78</td>
</tr>
<tr>
<td>128</td>
<td>Administer the maximal recommended doses of calcium, phosphate and vitamin D to prevent fractures in neonates with biochemical features of metabolic bone disease.</td>
<td>79</td>
</tr>
<tr>
<td>129</td>
<td>Stop steroids and furosemide as soon as possible in neonates at risk of metabolic bone disorder.</td>
<td>79</td>
</tr>
<tr>
<td>130</td>
<td>Start levothyroxine (L-T4) immediately in neonates with thyroid function test (TFT) that results in either a free T4 (FT4) concentration below norms for age or a venous TSH concentration &gt; 20 mIU/L.</td>
<td>80</td>
</tr>
<tr>
<td>131</td>
<td>Decrease glucose intake if necessary and decrease or stop drugs that worsen hyperglycemia, in neonates with hyperglycemia.</td>
<td>81</td>
</tr>
<tr>
<td>132</td>
<td>Start insulin only in patients with persistent hyperglycemia when other methods of glucose control have failed.</td>
<td>82</td>
</tr>
<tr>
<td>133</td>
<td>Do not provide high glucose infusion rates to prevent hypoglycemia in neonates receiving parenteral nutrition.</td>
<td>82</td>
</tr>
<tr>
<td>134</td>
<td>Do not use early insulin therapy in neonates at risk of hyperglycemia.</td>
<td>83</td>
</tr>
<tr>
<td>135</td>
<td>Start IV glucose infusion in asymptomatic neonates with serum glucose level of &lt;2.6 mmol/L if increased enteral caloric intake is not effective.</td>
<td>84</td>
</tr>
<tr>
<td>136</td>
<td>Start IV glucose infusion immediately in symptomatic neonates with glucose levels &lt;2.6 mmol/L.</td>
<td>85</td>
</tr>
<tr>
<td>137</td>
<td>Check the possible milk transfer of drugs taken by mothers to breastfed neonates, and monitor for potential adverse drug effects.</td>
<td>86</td>
</tr>
<tr>
<td>138</td>
<td>Check changes in drug effect when initiating strong inhibitors or inducers of the cytochrome P450 and/or P-glycoprotein.</td>
<td>87</td>
</tr>
<tr>
<td>139</td>
<td>Do not use ceftriaxone in neonates who are being, or who have recently been given any IV fluids that contain calcium (such as TPN or Ringer Lactate).</td>
<td>88</td>
</tr>
<tr>
<td>140</td>
<td>Do not use trimethoprim - sulfamethoxazole in neonates.</td>
<td>88</td>
</tr>
<tr>
<td>141</td>
<td>Check excipients contained in prescribed drug formulations administered orally or parenterally since they can be harmful and responsible for adverse events in neonates, due to immature metabolism.</td>
<td>89</td>
</tr>
</tbody>
</table>
### 01. BASIC MANAGEMENT

#### Body Care

<table>
<thead>
<tr>
<th>Item 1</th>
<th>Do not use routinely topical ointments in preterm neonates.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There is no evidence that the use of emollient therapy prevents invasive infection or death in preterm infants in high-income countries.</td>
</tr>
<tr>
<td>Grade of recommendations: FRN</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 2</th>
<th>Stop the use of antiseptics for the daily care of the uncomplicated umbilical cord in healthy hospitalized term neonates.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In high-income settings, there is limited research which has not shown an advantage of antibiotics or antiseptics over simply keeping the cord clean. Antimicrobial agent may actually delay the time to cord separation. On the contrary, there is high-quality evidence that chlorhexidine skin or cord care in the community setting results in reduction of the incidence of omphalitis and neonatal mortality.</td>
</tr>
<tr>
<td>Grade of recommendations: FRN</td>
<td></td>
</tr>
</tbody>
</table>

### All

<table>
<thead>
<tr>
<th>Basic Management/Body Care</th>
<th>Ointments</th>
<th>Antiseptics</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 37w GA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Item 3

**Administer a dose of DTPa-IPV/Hib ± HBV and of pneumococcal vaccine at 60, 90 and 120 days of postnatal life to all hospitalized preterm neonates.**

Hospitalized preterm infants should receive immunisation against diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b and pneumococcal at 2, 3 and 4 months of postnatal age. Use the combined vaccine. Cardiorespiratory function should be monitored in unstable preterm infants for 48 hours following immunisation. In preterm neonates <33 weeks of gestational age who will be discharged before their 60th day of postnatal age, the first dose of DTPa-IPV/Hib and of pneumococcal vaccine should be advanced. In this case, the immunisation can be administered from the 50th day of postnatal life, followed by booster vaccination 1 and 2 month later.

**Grade of recommendations: National Guidelines**


---

## Item 4

**Recommend BCG vaccine at discharge to neonates at high risk of tuberculosis exposure in the first year of life.**

BCG vaccine is recommended only to newborns at risk of developing disseminated tuberculosis. Infants at risk are those who come from AND will return definitely to regions with high prevalence of tuberculosis (Africa, Asia, Latine America, Eastern Europe) before the age of 1 year of postnatal life. Short stays (vacation) in those regions are not an indication for immunisation.

**Grade of recommendations: National Guidelines**

**Item 5**

**Check / administer Pertussis vaccination to close contacts of neonates.**

Preterm infants are at high risks of pertussis. Booster vaccination is recommended to the mother (unless immunized during pregnancy), the father (unless the last booster dates less than 10 years), the siblings (unless up-to-date), the grand-parents and/or all those who will be in close contact to the neonate before the age of 4 months (i.e. reception of 2 vaccine doses).

**Grade of recommendations: National Guidelines**


**Item 6**

**Check status and recommend or administer vaccination to close contacts of neonates.**

**Pertussis:** booster vaccination is recommended to the mother (unless immunized during pregnancy), the father (unless the last booster dates less than 10 years), the siblings (unless up-to-date), the grand-parents and/or all those who will be in close contact to the neonate before the age of 4 months (i.e. reception of 2 vaccine doses).

**Haemophilus influenzae type b:** catch-up vaccination to brothers and sisters <5 years old.

**Pneumococcal:** catch-up vaccination to brothers and sisters <5 years old.

**Influenza:** immunisation for all members of the family circle during the two first winters.

**ROR:** catch-up vaccination for all members of the family circle.

**Varicella:** catch-up vaccination for all members of the family circle.

**Grade of recommendations: National Guidelines**

### Item 7

Start parenteral nutrition shortly after birth in all preterm neonates when it is clear that enteral feeds will not be tolerated soon.

In the small preterm infant, starvation for just one day may be detrimental. Recommended volumes of parenteral nutrition:

- **<1500g BW (ml/kg/day):**
  - Day 1: Fluid 80-90 ml/kg/day
  - Day 2: Fluid 100-110 ml/kg/day
  - Day 3: Fluid 120-130 ml/kg/day
  - Day 4: Fluid 130-150 ml/kg/day
  - Day 5: Fluid 140-160 ml/kg/day
  - Day 6: Fluid 160-180 ml/kg/day
- **>1500g BW (ml/kg/day):**
  - Day 1: Fluid 60-80 ml/kg/day
  - Day 2: Fluid 80-100 ml/kg/day
  - Day 3: Fluid 100-120 ml/kg/day
  - Day 4: Fluid 120-150 ml/kg/day
  - Day 5: Fluid 140-160 ml/kg/day
  - Day 6: Fluid 140-160 ml/kg/day

**Target parenteral energy intake (including protein) of stable patients may be roughly estimated as 110-120 kcal/kg for preterm infants. Energy intake should be adapted in patients with disease states that increase resting energy expenditure, such as pulmonary and cardiac disorders but should not be increased after uncomplicated surgery.**

**Grade of recommendations: International Guidelines**


### Item 8

Start reducing the percentage of parenteral nutrition as quickly as possible by the introduction of enteral nutrition until enteral nutrition finally replaces completely PN in order to minimise any side-effects from exposure to PN.

Aim to reach full enteral feeding by about two weeks in babies weighing <1000 g at birth and by about one week in babies weighing 1000–1500g as clinically feasible.

**Grade of recommendations: National Guidelines**

Start continuous parenteral glucose administration in preterm infants needing parenteral nutrition.

An early start of parenteral glucose together with amino acids from the very first day onwards contributes to preventing hyperglycemia in premature infants. The recommended starting dose of glucose is 4-8 mg/kg/min (5.8-11.5 g/kg/day). Recommended parenteral glucose supply in parenteral nutrition:

- Neonates up to 3 kg: Day 1: 7 mg/kg/min (10 g/kg/day), Day 2: 9.7 mg/kg/min (14 g/kg/day), Day 3: 11.1 mg/kg/min (16 g/kg/day), Day 4: 12.5 mg/kg/min (18 g/kg/day).

Glucose intake should usually cover 60–75% of non-protein calories. These recommendations need to be adapted to the clinical situation to oral and/or enteral energy intake and to the required weight gain for normal or catch up growth. It is important, especially when prescribing PN for infants, to accurately evaluate the carbohydrate load provided by concurrent infusion therapy. An excessively high carbohydrate intake can result in net lipogenesis with hepatic fat deposition and steatosis of the liver.

Grade of recommendations: International Guidelines

Start amino acid supply in the first day of life in preterm infant needing parenteral nutrition.

Start with 1.5-2 g/kg/day and increase up to 3.5-4 g/kg/day. Amino acid imbalances can result in toxic organ damage and may be involved in the development of PN-associated cholestasis. Achieving an adequate energy to protein ratio is as important as providing adequate energy intake. Recommended non-protein energy to protein ratio depends on neonate age and weight and varies between 25 and 40 kcal/g of protein (=150-250 kcal/g of nitrogen). If energy intake is insufficient, protein is used as an energy source, and the nitrogen balance becomes less positive. Increasing the caloric intake will spare the protein loss and improve nitrogen retention, but with limited protein intake, the protein retention reaches a plateau, and the energy excess is used solely for fat deposition.

Grade of recommendations: B


### Item 11

Start continuous lipid emulsion infusion within the first 24-48 hours of life in preterm infant needing parenteral nutrition.

The initiation of lipids within the first 2 days of life in VLBW infants appears to be safe and well tolerated; however, beneficial effects on growth could not be shown for this treatment. Lipid intake should usually provide 25–40% of non-protein calories in fully parenterally fed patients. The recommended starting dose of lipid emulsions is 1-2 g/kg/day and is increased by 0.5-1.0 g/kg/day, up to 3 g/kg/day. No difference have been shown between the different lipid emulsion formulations. Reduction of the dosage of lipid emulsions should be considered if serum or plasma triglyceride concentrations during infusion exceed 250 mg/dL. In critically ill or infected patients receiving lipid emulsions, more frequent monitoring of plasma triglyceride concentration and dose adjustment in case of hyperlipidaemia are recommended. Lipid emulsions should be protected by validated light-protected tubing during phototherapy to decrease the formation of hydroperoxides.

**Grade of recommendations: B**


### Item 12

Do not administer parenteral lipid emulsion at a dose higher than 3-4 g/kg/day in neonates.

Maximum lipid oxidation of 4 g/kg/day is reached in full-term neonates with a glucose intake below 18 g/kg/day. An increase in the concentration of plasma triglycerides is to be expected if the infusion speed of the lipid emulsions exceeds the speed of hydrolysis of the triglycerides.

**Grade of recommendations: B**


Item 13

Check that a sufficient quantity of linoleic acid is administered in all neonates on parenteral nutrition.

In order to prevent Essential Fatty Acids (EFA) deficiency a minimum linoleic acid intake of 0.25 g/kg per day should be given to preterm infants and 0.1 g/kg per day to term neonates. Linoleic acid is contained in vegetal oils: soy oil (54%) and olive oil (10%). The approximate linoleic acid content in existing lipid solutions on the swiss market are:

- Lipofundin®: 29% of total lipids
- Lipoplus®: 24% of total lipids
- Omegaven®: 4% of total lipids
- SMOFlipid®: 19% of total lipids.

Grade of recommendations: D


Item 14

Start electrolytes supplementation with parenteral nutrition after onset of diuresis.

Recommended starting dose is sodium 2-3 mmol/kg/day, potassium 1-2 mmol/kg/day, calcium 0.6-0.8 mmol/kg/day, phosphates 1.0-1.2 mmol/kg/day and magnesium 0.3-0.4 mmol/kg/day.

Grade of recommendations: D


Start vitamins and trace elements supplementation in neonates receiving parenteral nutrition.

The optimum time to begin with trace element supplementation in premature infants <1500 g birth weight is not clear. It is proposed to start supplementation on the 5th day of life to coincide with an increase in body weight. Vitamin preparations should, if possible, be administered together with the lipid emulsion in order to limit light-induced lipid peroxidation and vitamin loss. Parenteral zinc supply is recommended in daily dosages of 450–500 mg/kg per day for premature infants.

Grade of recommendations: D


Start vitamin D supplementation from the first days of life in all neonates.

Recommended dose is 400 IU once daily during the first year of life and 600 IU once daily during the two next years.

Grade of recommendations: National Guidelines

## 2. CARDIOLOGY
### Congenital Heart Disease

### Item 17
**Start prostaglandin E1 (alprostadil) as an initial continuous intravenous infusion at 0.01 mcg/kg/min, until a definitive diagnosis is made in an infant suspected of having ductus-dependant heart disease.**

**Grade of recommendations: A**


### Item 18
**Reassess the indication of prostaglandin E1 (PGE1) treatment.**

Infants with Non Duct Dependent Lesions (Ventricular septal defect and others such as Atrioventricular canal defect) do not require PGE1 infusion.

**Grade of recommendations: Institutional Guidelines**


### Item 19
**Stop ibuprofen, indomethacin and paracetamol in patients with duct dependent congenital heart disease.**

Ibuprofen, indomethacin or paracetamol must not be used in patients with congenital heart disease in whom patency of the ductus arteriosus is necessary for satisfactory pulmonary or systemic blood flow (e.g. pulmonary atresia, severe tetralogy of Fallot, severe coarctation of the aorta).

**Grade of recommendations: Manufacturer**


**Patent Ductus Arteriosus (PDA)**

**Definition**
Confirmed patent ductus arteriosus (PDA)

Substantial ductal shunting may be associated with an increased ratio of left atrial to aortic root dimensions ≥1.5:1, ductal diameter ≥1.5 mm, left ventricular volume and pressure loading, and reversal of diastolic flow in the descending aorta or in cerebral or renal arteries.


---

**Item 20**

**Consider pharmacological closure of confirmed patent ductus arteriosus (PDA) in preterm neonates after 2 weeks of life, with ibuprofen as first-line treatment.**

Ibuprofen is as effective as indomethacin in closing a PDA and currently appears to be the drug of choice. Ibuprofen reduces the risk of NEC and transient renal insufficiency. Recommended dose is 10 mg/kg as the initial dose followed by 5 mg/kg 24 and 48 hours later. When possible, choose the enteral route for the administration of ibuprofen.

**Grade of recommendations: FRN**


---

**Item 21**

**Reassess the indication of ibuprofen, indomethacin and paracetamol in preterm neonates <2 weeks of life with confirmed or unconfirmed patent ductus arteriosus (PDA).**

The cumulative evidence supports the conclusion that early (in the first 2 weeks after birth), routine (as prophylaxis or for infants with echocardiographic confirmation of ductal patency with or without clinical signs) treatment to close the ductus arteriosus does not improve long-term outcomes for preterm infants.

**Grade of recommendations: National Guidelines**

### Item 22

**Reassess the indication of ibuprofen, indomethacin and paracetamol in term neonates with patent ductus arteriosus (PDA).**

<table>
<thead>
<tr>
<th>Stop</th>
<th>Cardiology/PDA</th>
<th>Ibuprofen, indomethacin, paracetamol</th>
</tr>
</thead>
</table>

In term neonates, inhibitors of prostaglandin synthesis are not effective for PDA closure, and thus are not recommended.

**Grade of recommendations: Textbook**


### Item 23

**Do not use paracetamol as first-line treatment for patent ductus arteriosus (PDA) closure. Consider a switch to ibuprofen.**

<table>
<thead>
<tr>
<th>Stop</th>
<th>Cardiology/PDA</th>
<th>Paracetamol</th>
</tr>
</thead>
</table>

Paracetamol appears to be a promising new alternative to indomethacin and ibuprofen for the closure of a PDA with potentially fewer adverse effects. Additional studies testing this intervention with long-term follow-up are needed before paracetamol can be recommended as standard treatment for a PDA in preterm infants.

**Grade of recommendations: FRN**

<table>
<thead>
<tr>
<th><strong>Hypotension</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td>Hypotension is defined as a mean blood pressure (MBP) &lt;30 mmHg or, during the first 3 days of postnatal life, a MBP with a number lower than the infant's gestational age in weeks.</td>
</tr>
</tbody>
</table>

| **Item 24** |
| Do not use volume expansion as first line treatment in VLBW infants (BW <1500g) with hypotension. |
| Hypotension in VLBW infants should be treated on the basis of the etiology of the hypotension, when an etiology is known. In general, the early use of volume expansion with normal saline solution, fresh frozen plasma, albumin, plasma substitute, or blood in VLBW infants with hypotension is not recommended. Evidence that VLBW infants with hypotension benefit from volume expansion is insufficient, as is the evidence to determine what type of volume expansion should be used in VLBW infants. The majority of VLBW infants who are hypotensive are not hypovolemic and have normal circulating blood volume. |
| **Grade of recommendations: National Guidelines** |

| <1500g BW |
| Cardiology/hypotension |
| Normal saline, fresh frozen plasma, albumin, plasma substitute, blood |

| **Item 25** |
| Consider a conservative approach (permissive hypotension) for the management of VLBW infants (BW <1500g) if the clinical examination is satisfactory in the face of apparent hypotension |
| A careful clinical and biochemical assessment of a potentially hypotensive infant is an essential first step towards management. This should include: heart rate, capillary refill time, urine output, serum lactate concentration, pH, base excess and haemoglobin. If a pharmacological treatment is considered, dopamine can be a valid option for the sole treatment of hypotension. Hydrocortisone may be as effective as dopamine when used as a primary treatment for hypotension. Clinical trials are underway and could provide stronger recommendations in the near future to guide clinicians in the management of the hypotension of the VLBW neonate. |
| **Grade of recommendations: FRN** |

| <1500g BW |
| Cardiology/hypotension |
03. HEMATOLOGY

Anemia

Item 26

Do not use routinely erythropoietin to limit exposure to blood transfusions in preterm neonates. The indication of treatment should be reassessed.

Aside from research about its possible neuroprotective potential (EPO appears to be a promising drug in many conditions where neonatal brain injury occurs), there is little current justification for the use of erythropoietin in neonatal medicine, except in a few limited situations (for example to respect the views of parents who are Jehovah’s witnesses).

Grade of recommendations: A


Item 27

Start iron supplement of 2-3 mg/kg/day in all preterm infants fed human milk once full oral feeds have been achieved.

This is the amount of iron supplied by iron-fortified formulas and infant fed with preterm formula do not need supplementation. Preterm infants fed human milk should receive an iron supplement of 2-3 mg/kg/day starting once full enteral feed have been achieved and continued until the infant is weaned to iron-fortified formula or begins eating complementary foods that supply the 2 mg/kg of iron. An exception to this practice would include infants who have received an iron load from multiple transfusions of packed red blood cells. Term healthy infants have sufficient iron for at least the first 4 months of life and should not receive iron supplementation. Supplementation with 4-6 mg/kg/day can be considered in newborns who are iron deficient. The available data suggest that infants who receive iron supplementation have a slightly higher haemoglobin level, improved iron stores and a lower risk of developing iron deficiency anaemia when compared with those who are unsupplemented. However, it is unclear whether iron supplementation in preterm and low birth weight infants has long term benefits in terms of neurodevelopmental outcome and growth.

Grade of recommendations: National Guidelines


### Item 28

**Start oral Vitamin K in neonates breastfed by a mother treated with phenprocoumone.**

Breastfed infants from mothers treated with phenprocoumone should receive oral vitamin K (phytomenadione) 1mg once a week. This doesn't apply if the mother is treated with acenocoumarol because of the short elimination half life of this drug.

**Grade of recommendations: National Guidelines**


### Item 29

**Check in all neonates that a complete Vitamin K prophylaxis has been given at birth.**

Adequate prophylaxis depends on clinical context and gestational age:
- Healthy neonates >34 weeks of gestational age; >2000g birthweight:
  - 4 hours after birth: 2 mg of oral phytomenadione
  - 4 days after birth: 2 mg of oral phytomenadione
  - 4 weeks after birth: 2 mg of oral phytomenadione
- Ill neonates / preterms with infusion / nil by mouth neonates:
  - 4 hours after birth: 0.5 mg of IV/IM phytomenadione
  - 4 weeks after birth: 2 mg of oral phytomenadione

**Grade of recommendations: National Guidelines**


### Risk factors for major bleeding in infant with thrombocytopenia:
- <1000g and <7 days
- Clinically unstable (e.g. fluctuating BP)
- Previous major bleeding (e.g. Grade 3-4 IVH, pulmonary haemorrhage)
- Current minor bleeding
- Concurrent coagulopathy
- Requiring surgery or exchange transfusion

**Definition**


### Consider platelets transfusion even in the absence of bleeding in all neonates with a platelet count of <30x10^9/L.

- The recommended volume of platelets to be transfused is 10-20 mL/kg. Transfuse over 30 minutes and monitor platelet count one hour post transfusion.
- In neonates receiving platelet transfusion, the administered platelet type should be:
  - Human platelet antigen (HPA) compatible platelets for neonates with neonatal allo-immune thrombocytopenia (NAIT), except in emergency situations in order to avoid delays to platelet transfusion; in that case, consider IV immunoglobulin (IVIG) (1-2 g/kg) in combination with the unmatched platelets.
  - Blood group-compatible, cytomegalovirus (CMV) negative for all other infants.
  - Irradiation of platelets is not routinely required but consider for babies with definite or suspected immunodeficiency or those who have undergone intrauterine transfusions.

**Grade of recommendations: Institutional Guidelines**


Item 31

Consider platelets transfusion in neonates with a platelet count of 30-49x10^9/L and minor bleeding or those at risk for major bleeding.

The recommended volume of platelets to be transfused is 10-20 mL/kg. Transfuse over 30 minutes and monitor platelet count one hour post transfusion. In neonates receiving platelet transfusion, the administered platelet type should be:
- Human platelet antigen (HPA) compatible platelets for neonates with neonatal allo-immune thrombocytopenia (NAIT), except in emergency situations in order to avoid delays to platelet transfusion; in that case, consider IV immunoglobulin (IVIG) (1-2 g/kg) in combination with the unmatched platelets.
- Blood group-compatible, cytomegalovirus (CMV) negative for all other infants.
- Irradiation of platelets is not routinely required but consider for babies with definite or suspected immunodeficiency or those who have undergone intrauterine transfusions.

Grade of recommendations: Institutional Guidelines


All Hematology/Thrombocytopenia and Platelet Dysfunction

Item 32

Consider platelets transfusion in neonates with a platelet count of 50-99x10^9/L only if bleeding is present.

The recommended volume of platelets to be transfused is 10-20 mL/kg. Transfuse over 30 minutes and monitor platelet count one hour post transfusion. In neonates receiving platelet transfusion, the administered platelet type should be:
- Human platelet antigen (HPA) compatible platelets for neonates with neonatal allo-immune thrombocytopenia (NAIT), except in emergency situations in order to avoid delays to platelet transfusion; in that case, consider IV immunoglobulin (IVIG) (1-2 g/kg) in combination with the unmatched platelets.
- Blood group-compatible, cytomegalovirus (CMV) negative for all other infants.
- Irradiation of platelets is not routinely required but consider for babies with definite or suspected immunodeficiency or those who have undergone intrauterine transfusions.

Grade of recommendations: Institutional Guidelines


All Hematology/Thrombocytopenia and Platelet Dysfunction
Item 33
Do not transfuse neonates with mild thrombocytopenia (platelet count 100-150x10^9/L) even if bleeding.

Grade of recommendations: Review


Item 34
Start intravenous immunoglobulin (IVIG) only in case of severe thrombocytopenia (platelet count of <50x10^9/L) or if bleeding persists despite compatible platelets transfusion or in combination with unmatched platelets transfusion in neonates with neonatal allo-immune thrombocytopenia (NAIT).

Recommended dose of IVIG is 1 g/kg, which can be repeated 24h after if thrombocytopenia persists.

Grade of recommendations: Institutional Guidelines


<table>
<thead>
<tr>
<th>Item 35</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start</strong></td>
</tr>
<tr>
<td><strong>Item 35</strong></td>
</tr>
<tr>
<td><strong>Start intravenous immunoglobulin (IVIG) as first line treatment in neonates with neonatal auto-immune thrombocytopenia and born to mothers who have idiopathic thrombocytopenic purpura (ITP), when platelet count is of &lt;30x109/L or clinical bleeding is present.</strong></td>
</tr>
<tr>
<td><strong>Recommended dose of IVIG is 1g/kg. Platelets transfusions are less likely to be effective and should be used as an adjuvant treatment for those who exhibit severe bleeding.</strong></td>
</tr>
</tbody>
</table>

**Grade of recommendations: Institutional Guidelines**


## Vasospasms and Thromboembolism

### Item 36

**Start unfractionned heparin or low molecular weight heparin in neonates with a first event venous thromboembolism for at least 5 days.**

**Unfractionned heparin:** 75 units/kg IV over 10 minutes, followed by 28 units/kg per hour continuous infusion. Four hours after initiating therapy, measure aPTT, then adjust dose to achieve an aPTT that corresponds to an anti-factor Xa level of 0.35 to 0.7 (this is usually equivalent to an aPTT of 60 to 85 seconds). Treatment should be limited to 10 to 14 days. Some experts recommend switching to low molecular weight heparin after 3 to 5 days. For renal vein thrombosis requiring treatment, 6 weeks to 3 months of heparin/low molecular weight heparin therapy is recommended.

**Low molecular weight heparin:** Eg: Enoxaparine:

- **Term infants:** initial, 1.7 mg/kg per dose subcutaneous every 12 hours.
- **Preterm infants:** initial, 2 mg/kg per dose subcutaneous every 12 hours.
- Adjust dosage to maintain anti-factor Xa level between 0.5 and 1.0 unit/mL. It will usually take several days to attain levels in the target range.
- Dosage requirements to maintain target anti-factor Xa levels in preterm infants are quite variable, ranging from 0.8 to 3 mg/kg every 12 hours.

**Grade of recommendations: National Guidelines**


### Item 37

**Start alteplase or urokinase only in case of major vessel occlusion causing critical compromise of organs or limbs in infants with venous thromboembolism.**

If thrombolysis is required, tissue plasminogen activator (tPA) (alteplase) or urokinase can be used, and plasminogen (fresh frozen plasma [FFP]) administration is suggested prior to start therapy. Alteplase recommended doses for dissolution of intravascular thrombi: 200 mcg/kg per hour (0.2 mg/kg per hour). Duration of therapy is 6 to 48 hours. If administering directly into the thrombus, dose may be increased after 6 hours to a maximum of 500 mcg/kg per hour. If localized bleeding occurs, stop infusion for 1 hour and restart using 100 mcg/kg per hour. Discontinue heparin several hours prior to initiation of therapy. Use urokinase as follows: try a dose of 5000 unit/kg an hour, and consider increasing the dose two- or even four-fold if blood flow does not improve within 8 hours.

**Grade of recommendations: National Guidelines**

### Oxygen saturation targets

**The lowest oxygen saturation level recommended to commence oxygen therapy:**
- **<36 weeks GA:** commence oxygen when saturations fall below 90% in ambient air
- **≥36 weeks GA:** commence oxygen when saturations fall below 93% in ambient air

**Target oxygen saturations and alarm limits for babies needing supplemental oxygen:**
- **<36 weeks GA:** 90-94%
- **≥36 weeks GA:** 93-97% (except infants with Persistent Pulmonary Hypertension of the Newborn: ≥95%).


### Pneumothorax

**Definition**
- **Primary pneumothorax:** pneumothorax without any obvious lung diseases.
- **Spontaneous pneumothorax (SP):** a form of primary pneumothorax in neonates. It usually occurs in the absence of inciting risk factors at birth.


#### Item 38

**Do not use routine supplemental oxygen use in infants with spontaneous pneumothorax.**

In infants with pneumothorax and respiratory distress, oxygen supplementation should be provided as needed to maintain adequate saturation. The rate of recovery for spontaneous pneumothoraces is not improved with oxygen supplementation or nitrogen washout (60 to 100% inspired O2 concentration) which expose infants to the risks of hyperoxia.

**Grade of recommendations: Cohort Study**


| ≥37w GA | Oxygen, nitrogen | Pneumology/Pneumothorax |
Clinically significant apnea of prematurity

Apnea is a cessation of breathing for 20 seconds or longer or a shorter pause accompanied by bradycardia (<100 beats per minute), cyanosis, or pallor.


Start caffeine citrate in patients with apnea of prematurity (loading dose 20 mg/kg; maintenance dose 5mg/kg/day). Dose may be increased to 10 mg/kg/day if apnea persists.

Caffeine citrate is a safe and effective treatment of apnea of prematurity and improves neurodevelopmental outcomes at 2 years of age. When caffeine is not available, use theophylline treatment at a 5-6 mg/kg loading dose and 2-6 mg/kg/day maintenance dose, divided every 8-12h. 2mg of caffeine citrate contains 1 mg of caffeine.

Grade of recommendations: Randomized Controlled Trial


### Item 40

**Reassess the need for caffeine citrate treatment.**

Timely discontinuation of methylxanthines is advised to avoid unnecessary delays in discharge. A clinically significant apnea event–free period before discharge of 7 days is recommended after methylxanthine discontinuation, although a longer period may be suitable for infants born at less than 26 weeks’ gestation.

**Grade of recommendations: National Guidelines**


### Item 41

**Reassess the indication of anti-gastroesophageal reflux therapy in neonates with apnea.**

Evidence suggests that gastroesophageal reflux (GER) is not associated with apnea of prematurity, and treatment of presumed or proven GER solely for the reduction in apnea events is not supported by currently available evidence.

**Grade of recommendations: National Guidelines**


<37w GA  |  Pneumology/Apnea  
|  Caffeine citrate  

<37w GA  |  Pneumology/Apnea  
|  Esomeprazole, Omeprazole  

---

*www.NeoCheck.ch  2020-2*
**Bronchopulmonary Dysplasia (BPD)**

<table>
<thead>
<tr>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronchopulmonary Dysplasia (BPD)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gestational Age</th>
<th>&lt; 32 wk</th>
<th>≥ 32 wk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time point of assessment</td>
<td>36 wk PMA or discharge to home, whichever comes first</td>
<td>&gt; 28d but &lt; 56d postnatal age or discharge to home, whichever comes first</td>
</tr>
<tr>
<td>Treatment with oxygen</td>
<td>≥ 21% for at least 28 d plus</td>
<td></td>
</tr>
</tbody>
</table>

| Mild BPD | Breathing room air at 36 wk PMA or discharge, whichever comes first |
| Moderate BPD | Need for 30% oxygen at 36 wk PMA or discharge, whichever comes first |

| Severe BPD | Need for ≥30% oxygen and/or positive pressure (PPV or NCPAP) at 36 wk PMA or discharge, whichever comes first |

**Definition of abbreviations:** BPD = bronchopulmonary dysplasia; NCPAP = nasal continuous positive airway pressure; PMA = postmenstrual age; PPV = positive-pressure ventilation

BPD usually develops in neonates being treated with oxygen and positive pressure ventilation for respiratory failure, most commonly respiratory distress syndrome. Persistence of clinical features of respiratory disease (tachypnea, retractions, rales) are considered common to the broad description of BPD and have not been included in the diagnostic criteria describing the severity of BPD. Infants treated with oxygen > 21% and/or positive pressure for nonrespiratory disease (e.g., central apnea or diaphragmatic paralysis) do not have BPD unless they also develop parenchymal lung disease and exhibit clinical features of respiratory distress. A day of treatment with oxygen > 21% means that the infant received oxygen > 21% for more than 12 h on that day. Treatment with oxygen > 21% and/or positive pressure at 36 wk PMA, or at 56 d postnatal age or discharge, should not reflect an “acute” event, but should rather reflect the infant’s usual daily therapy for several days preceding and following 36 wk PMA, 56 d postnatal age, or discharge.


**Item 42**

**Do not use dexamethasone in the prevention or the treatment of bronchopulmonary dysplasia.**

Administering high-dose dexamethasone to prevent or treat chronic lung disease (CLD) is not recommended. The routine use of low-dose dexamethasone for all infants who require assisted ventilation after seven days of age to prevent or treat CLD is not recommended.

**Grade of recommendations:** National Guidelines

### Item 43

**Do not use loop diuretics for prevention of BPD in preterm neonates.**

Current evidence does not support the use of loop diuretics for prevention of BPD.

**Grade of recommendations:** Review


<table>
<thead>
<tr>
<th>Item</th>
<th>Pneumology/Prevention of BPD OR Prevention/Prevention of BPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop</td>
<td>Furosemide, torasemide</td>
</tr>
</tbody>
</table>

### Item 44

**Do not use thiazid diuretics for prevention of BPD in preterm neonates. Use them judiciously for treatment of BPD in preterm neonates.**

No clear evidence is present for use of thiazide diuretics for the prevention or management of BPD. In patient with BPD, thiazide and spironolactone were shown to decreased oxygen requirement and improved lung function in the treatment group compared to placebo but failed to show any improvement in the survival rate, duration of oxygen requirement, or length of hospital stay.

**Grade of recommendations:** Review


<table>
<thead>
<tr>
<th>GA</th>
<th>Pneumology/BPD AND Pneumology/Prevention of BPD OR Prevention/Prevention of BPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;37w</td>
<td>Hydrochlorothiazid, chlorothalidone, spironolactone</td>
</tr>
</tbody>
</table>
### Definition

**Respiratory Distress Syndrome (RDS)**

- PaO₂ <50 mmHg (<6.6 kPa) in room air, central cyanosis in room air or need for supplemental oxygen to maintain PaO₂ >50 mmHg (>6.6 kPa), as well as the classical chest X-ray appearances.


---

### Item 45

Start surfactant therapy in infants born <26 weeks of gestational age who need FiO₂ >0.30.

In infants born <26 weeks of gestational age who need FiO₂ >0.30, porcine-derived surfactant poractant alpha therapy is recommended at a dose of 200 mg/kg. In infants with signs of persistent RDS and respiratory support, give 100 mg/kg 6-12 hours after the first dose and 12 hours after the second dose. Maximum dose is 400 mg/kg. Administering more than three doses of surfactant has not shown to have a benefit.

**Grade of recommendations: International Guidelines**


---

### Item 46

Start surfactant therapy in infants born ≥26 weeks of gestational age who need FiO₂ >0.40.

In infants born ≥26 weeks of gestational age who need FiO₂ >0.40, porcine-derived surfactant poractant alpha therapy is recommended at a dose of 200 mg/kg. In infants with signs of persistent RDS and respiratory support, give 100 mg/kg 6-12 hours after the first dose and 12 hours after the 2nd dose. Maximum dose is 400 mg/kg. Administering more than three doses of surfactant has not shown to have a benefit.

**Grade of recommendations: International Guidelines**


### Meconium Aspiration Syndrome

**Definition**

Meconium Aspiration Syndrome (MAS) Presence of respiratory distress and chest X-ray changes, not explained by other pathology, where there has been meconium stained amniotic fluid prior to delivery.


**Item 47**

**Start**

Consider inhaled nitric oxide (iNO) in neonates with hypoxic respiratory failure due to MAS.

For hypoxic respiratory failure due to MAS, infants responded well to combined iNO and high frequency ventilation treatment in comparison to either iNO or high frequency ventilation.

**Grade of recommendations:** Review


**Item 48**

Reassess the indication for antibiotics in patients with MAS alone.

Prophylactic use of antibiotics in meconium aspiration syndrome is not recommended unless there is an identified risk of infection.

**Grade of recommendations:** Review


**Item 49**

Administer a bolus instillation of surfactant in intubated infants with MAS requiring more than 50% oxygen.

In infants with MAS, surfactant administration may reduce the severity of respiratory illness and decrease the number of infants with progressive respiratory failure requiring support with extracorporeal membrane oxygenation (ECMO) (A). At the time of review, more trials are needed to evaluate the place of diluted surfactant as lavage therapy in MAS, and no recommendation can be made (FRN).

**Start**

**Grade of recommendations:** A


## Persistent Pulmonary Hypertension of the Newborn (PPHN)

### Definition

**Persistent Pulmonary Hypertension of the Newborn (PPHN)**

Elevated pulmonary vascular resistance and right-left shunt through the ductus arteriosus and/or foramen ovale, and absence of congenital heart abnormalities, demonstrated by echocardiography.

**Severe PPHN**

PPHN with an oxygenation index ≥25.


### Item 50

**Start inhaled nitric oxide (iNO) in neonates who have severe PPHN.**

Inhaled nitric oxide (iNO) is indicated to reduce the need for extracorporeal membrane oxygenation (ECMO) support in term and near-term infants with severe PPHN. Currently, the initial recommended concentration of iNO is 20 ppm. Using higher concentrations is not anymore effective, and is associated with a higher incidence of methemoglobinemia and formation of nitrogen dioxide (D). Once oxygenation improves, iNO can usually be weaned relatively rapidly to 5 ppm, and discontinued within 5 days. It should be weaned gradually in steps to the lowest dose possible for a period before discontinuation (D).

**Grade of recommendations: A**


### Item 51

**Do not use sildenafil as initial therapy for PPHN.**

Sildenafil is not recommended as initial therapy for PPHN when inhaled nitric oxide is available. Sildenafil can be used as adjunctive therapy for infants with PPHN who are refractory to iNO or to attenuate rebound pulmonary hypertension after iNO withdrawal or to shorten the time to extubation.

**Grade of recommendations: FRN**


Definition of acute kidney injury (AKI)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Serum Creatinine (SCr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No change in SCr or rise &lt;0.3 mg/dL</td>
</tr>
<tr>
<td>1</td>
<td>1.5–1.9 times reference SCr (lowest previous SCr value) OR ≥0.3 mg/dl (≥26.5 µmol/l) increase within 48h</td>
</tr>
<tr>
<td>2</td>
<td>2.0–2.9 times reference SCr</td>
</tr>
<tr>
<td>3</td>
<td>3.0 times reference SCr OR Increase in serum creatinine to ≥4.0 mg/dL (≥353.6 µmol/L) OR SCr ≥2.5 mg/dL OR Initiation of dialysis</td>
</tr>
</tbody>
</table>


Item 52

Do not use nephrotoxic drugs in neonates if possible, especially in preterm infants.

Nephron mass is lower in preterm infants since nephrogenesis is active until 36 weeks of gestational age and interruption of gestation results in a loss of total nephron number. Moreover, preterm infants are more vulnerable to acute kidney injury (AKI) with the potential loss of nephrons after birth. Nonsteroidal anti-inflammatory drugs (NSAIDs), including indomethacin and ibuprofen, paracetamol, aspirin, aminoglycosides (gentamicin, amikacin, tobramycin) and glycopeptide antibiotics (vancomycin, teicoplanin), betalactams (penicillins, cephalosporins), amphotericin B, antiviral agents (aciclovir), diuretics, proton pump inhibitors, and phenytoin can be nephrotoxic and cause AKI in neonates. This list is not exhaustive. When nephrotoxic agents must be started, monitor cystatin-C and/or serum creatinine before and after the initiation of treatment.

Grade of recommendations: Review


**Item 53**

**Stop all nephrotoxic drugs when possible in neonates with AKI (stage 1-3).**

Nonsteroidal anti-inflammatory drugs (NSAIDs), including indomethacin and ibuprofen, paracetamol, aspirin, aminoglycosides (gentamicin, amikacin, tobramycin) and glycopeptide antibiotics (vancomycin, teicoplanin), amphotericin B, antiviral agents (aciclovir), diuretics, and phenytoin can be nephrotoxic and cause AKI in neonates. This list is not exhaustive.

**Grade of recommendations: D**


<table>
<thead>
<tr>
<th>All</th>
<th>Nephrology/Acute Kidney Injury (AKI)</th>
<th>Nephrotoxics</th>
</tr>
</thead>
</table>

**Item 54**

**Consider dosage adjustment for drugs highly excreted by renal elimination in neonates with AKI (stage 1-3). When needed, refer to a specialist.**

**Grade of recommendations: D**

<table>
<thead>
<tr>
<th>All</th>
<th>Nephrology/Acute Kidney Injury (AKI)</th>
</tr>
</thead>
</table>
**6. GASTROENTEROLOGY**

**Direct hyperbilirubinemia (Conjugated Hyperbilirubinemia)**

**Definition**
Direct hyperbilirubinemia >17 μmol/L if total bilirubin is <85.5 μmol/L, or a value of direct bilirubin that represents >20% of the total bilirubin if total bilirubin is >85.5 μmol/L.


**Item 55**

**Decrease or stop intravenous soybean-based lipid emulsion in neonates with marked progressive cholestasis associated with parenteral nutrition.**

Consider switching soybean-based lipid emulsion to fish oil-based lipid emulsions or emulsions with reduced omega-6 fatty acids and increased omega-3 fatty acids. Examples of these type of lipid emulsions are Omegaven® (fish-oil), SMOFilipid® (soy-oil, medium-chain triglycerides, olive-oil, omega-3 fatty acids) and Lipoplus® (soy-oil, medium-chain triglycerides, omega-3 fatty acids).

**Grade of recommendations: International Guidelines**


### Item 56

**Administer adequate protein intake of 2 to 3 g/kg/day to neonates with direct hyperbilirubinemia.**

**Grade of recommendations:** Review


### Item 57

**Start fat-soluble vitamins (ADEK) in neonates with cholestasis.**

Prescribe fat-soluble vitamins during cholestasis and for 3 months following resolution of jaundice; doses will require daily monitoring. Follow your institution guidelines for dosage.

- Vitamin A: monitor serum vitamin A
- Vitamin D: Monitor bone biochemistry
- Vitamin E: monitor serum vitamin E
- Vitamin K: monitor PT and APTT

**Grade of recommendations:** National Guidelines


<table>
<thead>
<tr>
<th>Start</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consider ursodeoxycholic acid (UDCA) in neonate with direct hyperbilirubinemia.</strong></td>
</tr>
<tr>
<td>Consider ursodeoxycholic acid (UDCA) treatment at the dosage of 20–30 mg/kg/day in divided doses until jaundice resolve. Ursodeoxycholic acid (UDCA) has been found to have beneficial effects on many forms of cholestasis, and is generally used as first-line therapy for pruritus due to cholestasis, parenteral nutrition-induced cholestasis, biliary atresia after surgical treatment, and α1-antitrypsin deficiency (C).</td>
</tr>
</tbody>
</table>

**Grade of recommendations: National Guidelines**


<table>
<thead>
<tr>
<th>Item 59</th>
<th>Indirect hyperbilirubinemia (Unconjugated Hyperbilirubinemia)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start</strong></td>
<td>Administer intravenous immunoglobulin (IVIG) to neonates with a positive direct Coombs test and severe hyperbilirubinemia, or to those progressing to severe hyperbilirubinemia despite initial treatment.</td>
</tr>
<tr>
<td>IVIG should be administered, if not so already, in infants with isoimmunisation.</td>
<td>Dose: 1 g/kg</td>
</tr>
</tbody>
</table>

All Gastroenterology/Indirect hyperbilirubinemia
### Definition

**Necrotizing Enterocolitis (NEC)**

<table>
<thead>
<tr>
<th>Review of Bell’s Stages</th>
<th>Clinical Findings</th>
<th>Radiographic Findings</th>
<th>Gastrointestinal Findings</th>
<th>Bell’s stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Apnea and bradycardia, temperature instability</td>
<td>Normal gas pattern or mild ileus</td>
<td>Gastric residuals, occult blood in stool, mild abdominal distention</td>
<td>Suspect</td>
</tr>
<tr>
<td>Stage II A</td>
<td>Apnea and bradycardia, temperature instability</td>
<td>Ileus gas pattern with one or more dilated loops and focal pneumatosis</td>
<td>Grossly bloody stools, prominent abdominal distention, absent bowel sounds</td>
<td>Proven</td>
</tr>
<tr>
<td>Stage II B</td>
<td>Thrombocytopenia and mild metabolic acidosis</td>
<td>Widespread pneumatosis, ascites, portal-venous gas</td>
<td>Abdominal wall edema with palpable loops and tenderness</td>
<td></td>
</tr>
<tr>
<td>Stage III A</td>
<td>Mixed acidosis, oliguria, hypotension, coagulopathy</td>
<td>Prominent bowel loops, worsening ascites, no free air</td>
<td>Worsening wall edema, erythema and induration</td>
<td>Advanced</td>
</tr>
<tr>
<td>Stage III B</td>
<td>Shock, deterioration in laboratory values and vital signs</td>
<td>Pneumoperitoneum</td>
<td>Perforated bowel</td>
<td></td>
</tr>
</tbody>
</table>


### Item 60

**Start probiotics in preterm neonates at high risk of developing NEC.**

In patient at high risk of developing NEC (preterm < 32 weeks GA or <1500g), initiate a probiotic treatment, with a preparation combining Lactobacillus and Bifidobacterium species. Initiate at the time of the first feed until 36 weeks of gestational age or discharge. Use only probiotic drugs fulfilling pharmaceutical regulations.

**Grade of recommendations: Systematic Review / Meta-analysis**


**Item 61**

Stop all enteral medications in neonates suspected to have NEC.

When an infant is suspected to have NEC (stage I), all enteral medications should be discontinued. Enteral route can be used again if investigation exclude NEC. In stage II-III NEC, enteral route must not be used for 7-14 days to allow gastrointestinal rest.

**Grade of recommendations: Review**


---

**Item 62**

Do not use enteral antibiotics for the prevention of NEC.

Evidence suggests that enteral antibiotics reduce the incidence of NEC in low birth weight infants. However, concerns about adverse outcomes persist, particularly related to the development of resistant bacterial infection.

**Grade of recommendations: Systematic Review / Meta-analysis**


---

**Item 63**

Start broad spectrum antibiotic promptly after blood cultures have been drawn in neonates with any stage of NEC.

After blood cultures have been drawn, prompt initiation of treatment with IV gentamicin and amoxicillin. If evolving to Bell’s stage II-IV NEC, antibiotic treatment should be continued for 7 to 14 days. Follow your institution guideline for dosage.

**Grade of recommendations: Textbook**


Check that a Vitamin K prophylaxis was administered postdelivery in neonates with upper gastro-intestinal bleeding, to guide diagnostic.

All neonates who have hematemesis should be screened for coagulopathy due to:
- failure to administer prophylaxis postdelivery
- maternal thrombocytopenic purpura
- hemophilia
- von Willebrand disease

Grade of recommendations: Review

**Gastroesophageal Reflux**

<table>
<thead>
<tr>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastroesophageal Reflux (GER)</strong>&lt;br&gt;Gastroesophageal reflux is physiologic in the neonate. Only rarely does reflux become a &quot;disease&quot; (GERD).&lt;br&gt;&lt;br&gt;<strong>Gastroesophageal Reflux Disease (GERD)</strong>&lt;br&gt;Causing overt oesophagitis or is associated with other symptoms. This should be assessed by clinical judgment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 65</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consider proton pump inhibitors or H2-blockers only in neonates with severe cases of acid gastroesophageal reflux disease (GERD), when non-pharmacological measures (including milk thickeners) have failed.</strong></td>
</tr>
</tbody>
</table>

**Start / stop**

Do not offer acid-suppressing drugs, such as proton-pump inhibitors or H2-receptor antagonists, to treat overt regurgitation in infants with isolated symptoms. In severe cases of GERD, omeprazole should be administered orally at an initial dose of 0.7 mg/kg once a day. It can be raised to a maximum dose of 1.4 mg/kg once a day after 7-14 days if this does not inhibit gastric acid production. IV use: Give 0.5 mg/kg once a day over 5 min. Recommended dose of ranitidine is 1.5 mg/kg 3x/day for term infants and 0.5 mg/kg 3x/day for preterm infants. Treatment should be reassessed regularly.

**Grade of recommendations: National Guidelines**

Do not use metoclopramide, domperidone or erythromycin to treat gastroesophageal reflux or gastroesophageal reflux disease.

Pro-kinetics such as metoclopramide and domperidone are not recommended for the treatment of GER due to lack of evidence and concerns regarding adverse effects. Erythromycin has limited benefit, may facilitate bacterial resistance and should not be routinely prescribed.

Grade of recommendations: National Guidelines


### Seizures

**Definition**

A seizure is defined clinically as a paroxysmal alteration in neurologic function. This definition includes:

1. **Epileptic seizures**: phenomena associated with corresponding EEG seizure activity e.g. clonic seizures
2. **Non-epileptic seizures**: clinical seizures without corresponding EEG correlate e.g. subtle and generalized tonic seizures
3. **EEG seizures**: abnormal EEG activity with no clinical correlation.


### Item 67

**Start** phenobarbital as the first line agent in neonates with either EEG diagnosed or clinically apparent seizures when prolonged or frequent.

Phenobarbital should be used as the first line agent (at a loading dose of 20 mg/kg IV over 10-15 min and a maintenance dose of 2.5-5 mg/kg IV, IM or oral, once daily beginning 12-24h after loading dose) in neonates with either EEG diagnosed or clinically apparent seizures when prolonged (greater than 3 minutes), frequent (greater than 3 per hour). Phenobarbital is recommended as first-line treatment given its inclusion in the only RCT of first-line treatment of neonatal seizure, the fact that it is the most studied anti-epileptic medication in animals, and its historical precedence as the first-line antiepileptic drug for neonates. Use phenobarbital with caution since there is extremely limited evidence on its effect on long-term neonatal neurodevelopment.

**Grade of recommendations: International Guidelines**


**Item 68**

Consider phenytoin or a benzodiazepine or lidocaine in neonates with persistant seizures, despite adequate phenobarbital treatment.

In neonates who continue to have seizures despite administration of the maximal tolerated dose of phenobarbital, either phenytoin or a benzodiazepine or lidocaine may be used as the second-line agent for the control of seizures. The use of phenytoin or lidocaine requires cardiac monitoring facilities.

**Grade of recommendations: International Guidelines**


**Item 69**

Stop antiepileptic drugs if seizure-free for >72 hours in neonates with normal neurological examination and/or normal electroencephalography.

In neonates in whom seizure control is achieved with a single antiepileptic drug, the drug can be discontinued abruptly without any tapering of doses. In neonates requiring more than one antiepileptic drugs for seizure control, the drugs may be stopped one by one, with phenobarbital being the last drug to be withdrawn.

**Grade of recommendations: International Guidelines**


**Item 70**

Consider pyridoxine only in neonates with recurrent seizures with no obvious cause.

If there are recurrent seizures with no obvious cause consider pyridoxine dependency. A therapeutic trial of pyridoxine IV 50 -100 mg may be helpful (this may be considered during EEG).

**Grade of recommendations: International Guidelines**

### Item 71

Start pain management in neonates with non-pharmacological techniques (incl. Sucrose) if appropriate.

If moderate-severe pain is evident (including post-surgery, severe illness, major injury, congenital malformations or palliative care), progress to pharmacological agents.

**Grade of recommendations: Institutional Guidelines**


### Item 72

Start paracetamol in neonates who are still in pain despite adequate non-pharmacological interventions.

Recommended doses are 10–15 mg/kg orally or 20–25 mg/kg rectally administered every 6–8 hours. Recommendations for intravenous paracetamol, are a loading dose of 20 mg/kg, followed by 10 mg/kg every 6–8 hours. Maximum doses should not exceed 40 mg/kg/day for infants at 26–32 weeks PMA and 60 mg/kg/day for infants at 32–42 weeks PMA. Hepatotoxicity occurs very rarely, if ever, following routine administration of paracetamol in neonates. Priority to the oral route.

**Grade of recommendations: International Guidelines**


Do not use nonsteroidal antiinflammatory agents (NSAID) as analgesics.

NSAIDs are not recommended for neonatal analgesia, as safer and more effective agents are available. Treatment should be switched to other pharmacologic classes.

Grade of recommendations: International Guidelines


Start morphone as first line treatment for pain relief in neonates who are still in pain despite adequate non-pharmacological techniques and paracetamol treatment.

Morphine is recommended as the first-line strong opioid for the treatment of persistent moderate to severe pain in children with medical illnesses. There is insufficient evidence to recommend any alternative opioid in preference to morphine as the opioid of first choice. Intermittent dose 50-100 μg/kg IV every 4-8 hours, Infusion dose 10-30 μg/kg/h (for opioid naive patients). Start at the lower dose and titrate carefully to effect using small incremental doses. When opioids are administered for greater than 4 days, physical dependence and tolerance may develop. This means that higher opioid doses are required in order to maintain patient comfort and that treatment should be weaned over a period of days at the rate of 10% of the prescribed dose per day, based on the clinical assessment of the neonate. Caution should be taken when treating newborns with opioids, especially preterm neonates, as they are more sensitive to opioids and are at risk for respiratory depression, apnea, hypotension and urinary retention.

Grade of recommendations: International Guidelines


Start opioids as first line treatment for postoperative analgesia, and use them as long as pain assessment scales deem necessary.

Morphine dosage: intermittent dose 50-100 μg/kg IV every 4-8 hours, Infusion dose 10-30 μg/kg/h (for opioid naive patients). Clinical titration using small incremental doses (5–20 μg/kg) may be required. When opioid are administered for greater than 4 days, physical dependence and tolerance may develop. This means that higher opioid doses are required in order to maintain patient comfort and that treatment should be weaned over a period of days at the rate of 10% of the prescribed dose per day, based on the clinical assessment of the neonate. Caution should be taken when treating newborns with opioids, especially preterm neonates, as they are more sensitive to opioids and are at risk for respiratory depression, apnea, hypotension and urinary retention.

Grade of recommendations: International Guidelines


### Item 76

**Reassess the indication of morphine or fentanyl in chronically ventilated preterm neonates without pain.**

In the absence of pain, discomfort or difficulties for improving gas exchange, use of continuous infusions of morphine or fentanyl in chronically ventilated preterm neonates is not recommended. There is insufficient evidence to recommend routine use of opioids in mechanically ventilated newborns. Opioids should be used selectively, when indicated by clinical judgment and evaluation of pain indicators. If sedation is required, morphine is safer than midazolam. Newborns, especially preterm neonates, are more sensitive to opioids and are at risk for respiratory depression, apnea, hypotension, and urinary retention.

**Grade of recommendations: National Guidelines**


---

### Item 77

**Do not use ketamine treatment for routine management of pain.**

In spite of its theoretical advantages, ketamine is a potent anesthetic that has received minimal study in neonates. As such, it should only be used for surgery or highly invasive procedures.

**Grade of recommendations: FRN**


**Neonatal Abstinence Syndrome (NAS)**

**Item 78**

Consider non-pharmacological interventions for the initial management of all infants suspected of having or at risk of developing NAS. This may mitigate the need for medication.

Infants at risk for NAS should be monitored diligently during the initial days after birth. At present, the modified Finnegan scores remains the most common tool that is used. Start modified Finnegan scoring within 24h of birth and monitor score every 3-4h. Treatment is indicated when the average of three scores is ≥8 or when the average of two scores is ≥12.

**Grade of recommendations: National Guidelines**


**Item 79**

Start morphine as the first line pharmacological treatment for NAS when opioids are used by the mother and supportive measures failed.

Morphine is indicated when the average of three Modified Finnegan Scores is ≥8 on the scoring tool or when the average of two scores is ≥12. Recommended doses for oral morphine are variable. Try 50 µg/kg every 3–4 h, then 10% or 50 µg increments to a maximum dose of 1300 µg/kg/day. Phenobarbital should be considered at this point.

**Grade of recommendations: National Guidelines**


### Item 80

**Start weaning of morphine as soon as Modified Finnegan scores are <8 for 24 to 48 hours in neonates with NAS.**

Initiate weaning of morphine when Modified Finnegan scores are <8 for 24 to 48 hours by a 10% decrease of the total daily dose with each wean occurring no more frequently than every 48 to 72 hours. Morphine can be discontinued when scores are stable for 48 to 72 hours on a dose of 0.05 to 0.1 mg/kg/day.

**Grade of recommendations: Institutional Guidelines**


| All | Pain, analgesia & neonatal abstinence syndrome/NAS
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Morphine</td>
</tr>
</tbody>
</table>

### Item 81

**Do not use morphine in neonates with NAS when the drugs used by the mother are non-opioids.**

If needed, use phenobarbital (see phenobarbital recommendations).

**Grade of recommendations: D**

| All | Pain, analgesia & neonatal abstinence syndrome/NAS
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Morphine, opioids</td>
</tr>
</tbody>
</table>
## 09. INFECTIOLOGY
### Meningitis

<table>
<thead>
<tr>
<th>Item 82</th>
<th>Start empirical antibiotic treatment with high dose amoxicillin and gentamicin in neonates with diagnosed or strongly suspected meningitis.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow your institution guidelines for dosage.[4]</td>
</tr>
<tr>
<td></td>
<td><strong>Grade of recommendations: Textbook</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 83</th>
<th>Check results of cerebro-spinal fluid (CSF) culture as soon as they are available in order to reassess the need for treatment or the choice of antibiotics in neonates with suspected meningitis treated with empirical antibiotics.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If low clinical suspicion of meningitis, stop antibiotics after 48 hr if:</td>
</tr>
<tr>
<td></td>
<td>- CSF glucose &gt; 2/3 simultaneous blood glucose and</td>
</tr>
<tr>
<td></td>
<td>- CSF protein &lt; 1 g/L, culture results are negative and baby remains well.</td>
</tr>
<tr>
<td></td>
<td><strong>Grade of recommendations: Institutional Guidelines</strong></td>
</tr>
</tbody>
</table>
Do not use corticosteroids for the treatment of neonates with suspected or confirmed bacterial meningitis. Reassess the corticosteroid indication.

At present, there is insufficient data to make a recommendation on the use of adjunctive corticosteroids in neonates with bacterial meningitis. Very low-quality data from two randomised controlled trials suggest that some reduction in death and hearing loss may result from use of adjunctive steroids alongside standard antibiotic therapy for treatment of patients with neonatal meningitis. Benefits are not yet seen with regards to a reduction in neurological consequences.

Grade of recommendations: FRN


**Sepsis**: According to the onset of age, neonatal sepsis is divided into early-onset sepsis (EOS) and late-onset sepsis (LOS). EOS reflects transplacental or, more frequently, ascending infections from the maternal genital tract, whereas LOS is associated with the postnatal nosocomial or community environment, with the peak incidence reported to be between the 10th and 22nd day of life. The onset of LOS is most frequently defined at 72 h after birth, a cut-off time point considered to adequately differentiate LOS from EOS in terms of the spectrum of causative pathogens

**Early-Onset Sepsis (EOS):** Onset of sepsis symptoms during the first 72 hours of life.
*Risk factors of EOS:*
- Maternal group B Streptococcus colonisation;
- Signs of chorioamnionitis (maternal fever >38 °C plus at least two of the following symptoms: maternal leucocytosis (>15 G/l), foetal tachycardia (>160/min), uterine tenderness, foul-smelling amniotic fluid);
- Prolonged rupture of membranes (>18 hours before delivery),
- Preterm birth <37 weeks,
- Previous neonate with an invasive group B streptococcus infection;
- Suspected infection in a sibling in the case of a multiple pregnancy.

**Late-Onset Sepsis:** Onset of sepsis symptoms at 72 hours of life or later.
*Risk factors of LOS:*
- Risk of infection is inversely related to gestational age and birth weight and directly related to severity of illness at birth, reflecting need for invasive interventions e.g. prolonged ventilation, central venous access and parenteral nutrition.
- Delayed introduction of enteral feeds is associated with higher infection rates
- Increased risk of sepsis after gut surgery especially if enteral feeds slow to establish e.g. post-gastrostomosis or necrotising enterocolitis (NEC) with stoma

**Symptoms of sepsis:**
- Tachypnoea, respiratory distress, apnoea;
- Tachycardia/bradycardia, poor peripheral perfusion (i.e. capillary refill time >3 seconds), mottling;
- Temperature instability (hyperthermia >38.0 °C or hypothermia <36.0 °C);
- Lethargy, irritability, altered muscular tone or floppiness;
- Vomiting, poor feeding.

**Definition**


**Item 85**

<table>
<thead>
<tr>
<th>Do not use empirical antibiotic therapy for asymptomatic neonates with a single risk factor of infection (incl. mother with suspected chorioamnionitis or unexplained premature delivery).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only close observation for the first 48 hours is advised.</td>
</tr>
<tr>
<td>Grade of recommendations: National Guidelines</td>
</tr>
</tbody>
</table>

**Item 86**

<table>
<thead>
<tr>
<th>Start empirical antibiotic treatment after blood cultures have been drawn in all newborn infants with suggestive signs of neonatal infection.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use amoxicillin and gentamicin at doses recommended by your institution. There is a need for therapeutic drug monitoring for aminoglycoside therapy (aiming for a residual gentamicine blood concentration of 0.5-2 mg/L before 3rd dose).</td>
</tr>
<tr>
<td>Grade of recommendations: National Guidelines</td>
</tr>
</tbody>
</table>
### Item 87

**Reassess the need for antibiotics after 48 hours in neonates treated empirically with antibiotics for suspected sepsis.**

This is important since clinical and laboratory signs of neonatal infection are nonspecific and symptomatic neonates are treated empirically. In most cases, based on the clinical course, negative culture results and laboratory parameters, a decision can be made to stop safely antibiotic therapy after this time (C-reactive protein (CRP) and procalcitonin (PCT) have a high negative predictive value and can be used to stop empirically started antibiotic therapy early). Frequently, prolonged antibiotic therapy (>5 days) causes an increased mortality and a higher incidence of necrotising enterocolitis in preterm infants. This emphasises the need to stop empirical treatment in the absence of proven infection as early as possible and at the latest after 48–72 hours.

**Grade of recommendations: National Guidelines**


### Item 88

**Do not use cephalosporins as first-line treatment in infant with suspected neonatal infection, because of the high risk of developing resistance. Use is restricted to special cases**

**Grade of recommendations: National Guidelines**

Item 89

Do not use intravenous immunoglobulin in the treatment of suspected or proven neonatal sepsis.

Therapy with intravenous immunoglobulin had no effect on the outcomes of suspected or proven neonatal sepsis and should be discontinued.

Grade of recommendations: Randomized Controlled Trial


Item 90

Do not use Vancomycin as prophylaxis against sepsis in preterm neonates.

Vancomycin prophylaxis should not be undertaken in preterm infants with additional risk factors for infection such as a birth weight less than 1500 grams, use of central venous catheters, and administration of intravenous hyperalimentation.

Grade of recommendations: FRN

### Item 91

Administer an initial dose of hepatitis-B vaccine within 12 hours of birth in infants born to HBsAg-positive mothers, including infants weighing <2000g. Administer Hepatitis-B immune globulins (HBIG) 200 IU concurrently but at a different anatomic site.

The later HBIG is administered after exposure, the less it is effective. The interval of effectiveness is unlikely to exceed 7 days. For infants who weigh less than 2000g at birth, the initial vaccine dose should not be counted in the required 3-dose schedule. Give low-birth-weight and premature babies full neonatal dose of hepatitis B vaccine. Monitor infants born <28 weeks of gestational age for 72h after HBIG.

**Grade of recommendations:** National Guidelines

| Groupe de travail “Prévention de la transmission mère-enfant de l’hépatite B”;


### Item 92

Do not use early hepatitis-B vaccine in infants born to mothers whose HBsAg and HBeAg status is negative but with positive anti-HBs status (prior infection or at risk of infection).

They should receive three hepatitis-B vaccine doses at 2, 3 and 4 months of life along with other recommended vaccines (DTPa-IPV-Hib).

**Grade of recommendations:** Institutional Guidelines

**Item 93**

**Start HIV prophylaxis with zidovudine as close to birth as possible for at least 4 weeks or consider tritherapy in neonates born to HIV-infected mothers who did not follow proper antenatal treatment or whose viremia are detectable.**

Follow your institution guidelines for doses.

**Grade of recommendations: National Guidelines**


---

**Item 94**

**Start tritherapy immediately in the neonate aged <72 hr if the mother is diagnosed postpartum with HIV infection.**

Follow your institution guidelines for the choice of molecule and doses.

**Grade of recommendations: Institutional Guidelines**

### Respiratory Syncytial Virus (RSV)

<table>
<thead>
<tr>
<th>Item 95</th>
<th>Start / Stop</th>
<th>Start respiratory syncytial virus prophylaxis with palivizumab in neonates with severe bronchopulmonary dysplasia (BPD).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Use palivizumab 15 mg/kg/dose IM once a month during RSV season (~October till February). In those with moderate BPD, consider palivizumab prophylaxis. Palivizumab is not indicated for neonates with mild BPD.</td>
</tr>
</tbody>
</table>

**Grade of recommendations: National Guidelines**


<table>
<thead>
<tr>
<th>Item 96</th>
<th>Start / stop</th>
<th>Start respiratory syncytial virus prophylaxis with palivizumab in neonates with haemodynamically significant congenital heart disease AND other associated risk factors.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Use palivizumab 15 mg/kg/dose once every month during RSV season (~October till February). It is not advised to administer such prophylaxis in infants solely with haemodynamically significant congenital heart disease. Associated risk factors: cyanotic heart disease, severe pulmonary hypertension and overt heart failure.</td>
</tr>
</tbody>
</table>

**Grade of recommendations: National Guidelines**

Item 97

**Do not use respiratory syncytial virus prophylaxis with palivizumab routinely in preterm neonates.**

This statement was made considering:
- The modest efficacy of palivizumab;
- That in Switzerland the outcomes of hospitalization due to RSV infection in former preterm neonates without additional risk factors did not differ substantially from those of term neonates;
- The high cost of palivizumab.

**Grade of recommendations: National Guidelines**


---

Item 98

**Do not use palivizumab for the treatment of respiratory syncytial virus (RSV) infection. Stop the treatment, even if it was given before the infection.**

**Grade of recommendations: National Guidelines**


**Toxoplasmosis**

**Definition**

**Confirmed Case:**
- Clinical illness in a child with laboratory evidence of Toxoplasma gondii infection born to a mother with documented seroconversion during pregnancy (post-conceptually)
- Laboratory confirmation of infection in the neonate with or without clinical illness:
  - Detection of IgA and/or IgM antibodies to T. gondii from a single peripheral blood specimen from the neonate
  - Demonstration of rising T. gondii IgG titres in sequential sera from the neonate
  - Detection of T. gondii nucleic acid (e.g., PCR) in amniotic fluid, placental tissue, fetal or neonatal tissue, blood or CSF
  - Isolation of T. gondii from blood or body fluid of the neonate by mouse inoculation
  - Microscopic demonstration of T. gondii in an appropriate neonatal clinical specimen.

**Clinical illness:** Fetal infection early in pregnancy may manifest as fetal death, chorioretinitis, brain damage with intracerebral calcifications, hydrocephaly, microcephaly, fever, jaundice, rash, hepatosplenomegaly, or convulsions. Fetal infection later in pregnancy results in mild or subclinical disease with delayed manifestations (recurrent or chronic chorioretinitis, developmental delay, hearing loss or blindness).

**Probable Case:**
- Clinical illness in a child with laboratory evidence of T. gondii infection born to a seropositive mother
- Clinical illness in a neonate born to a female with reactivated toxoplasma infection (rare).


**Item 99**

Administer a combination of pyrimethamine-sulfadiazine-folinic acid during the first year of life to neonates in whom a diagnosis of congenital toxoplasmosis is confirmed or probable.

Follow your institution guideline for dosage.

**Grade of recommendations:** Textbook


**Item 100**

Do not use spiramycin in neonates. Stop treatment and screen for potential QT interval prolongation.

Spiramycin is no longer used in suspected toxoplasmosis. It was indicated in the past while waiting for a conclusive diagnosis, but no benefit has ever been demonstrated and it can cause cardiac toxicity (QT prolongation).

**Grade of recommendations:** Review


All Infectiology/Toxoplasmosis

Spiramycin
Life-threatening disease:
- Viral sepsis-like syndrome
- Pneumonitis
- Myocarditis
- Severe hepatitis
- Enterocolitis
- Severe and refractory thrombocytopenia
- Sight-threatening retinitis
- Severe neurologic disease
- Underlying primary immune disorder (e.g., severe combined immunodeficiency [SCID]) regardless of degree of symptoms

Severe focal disease is defined as severe hepatitis, severe bone marrow suppression, colitis or pneumonia.


Start antiviral treatment as soon as virologic testing is confirmed and within the first 30 days of life in symptomatic cytomegalovirus (CMV) infected newborns with central nervous system involvement or if life-threatening.

Treatment can be considered in symptomatic newborns with severe focal disease. IV ganciclovir and oral valganciclovir can be used, depending on the severity of the disease. Follow your institution guideline for dosage. Monitor full blood count, liver function tests, creatinine, urea and electrolytes. Suspend treatment if absolute neutrophil count < 500/µL or platelet count < 25 000/µL. Asymptomatically infected or mild/moderate symptomatic neonates should not be treated with antiviral agents.

Grade of recommendations: National Guidelines


Stop antiviral treatment in neonates with asymptomatic cytomegalovirus infection

Antiviral therapy is not recommended routinely in neonates and young infants because of possible toxicities, including neutropenia in a significant proportion of recipients.

Grade of recommendations: International Guidelines


**Clinical suspicion of neonatal herpes infection:**
Since most neonatal herpes infections occur where the mother has no history of genital herpes, an HSV infection must be suspected immediately if the neonate exhibits suspicious symptoms (B).
The possibility of neonatal herpes infection must be especially considered in case of:
- characteristic skin or mucosal lesions
- conjunctivitis, particularly if there is injection of the conjunctiva, bulbi, or keratitis
- seizures and/or lethargy without any other explanation
- fever or other systemic symptoms without any other explanation.


**Item 103**

**Start aciclovir IV in neonates with Herpes Simplex Virus (HSV) disease, regardless of maternal history or pending laboratory confirmation or exclusion of HSV.**

Localised HSV infections (skin, eyes and mouth) are treated for 14 days with parenteral aciclovir and CNS forms or disseminated infection for 21 day (C). Follow your institution guideline for dosage. For infants with CNS disease, CSF should be sampled near the end of a 21-day course of therapy. If the PCR remains positive, treatment should be extended with weekly CSF sampling and aciclovir stopped when a negative result is obtained (D). After acute HSV treatment, suppressive therapy with oral aciclovir should be given for six months to infants with CNS disease (D). Do not treat acute HSV infection with oral aciclovir because this leads to non-therapeutic drug levels (D).

**Grade of recommendations: National Guidelines**


<table>
<thead>
<tr>
<th>Start</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start a topical antiviral treatment in combination with aciclovir IV in neonates with Herpes Simplex Virus (HSV) disease with ocular involvement.</strong></td>
</tr>
<tr>
<td>An ophthalmological consultation should be advised.</td>
</tr>
<tr>
<td><strong>Grade of recommendations: National Guidelines</strong></td>
</tr>
</tbody>
</table>
### Item 105

**Start Varicella-Zoster Immune Globulin (VZIG) 125IU IM as soon as exposure is known and within a 72 hour period, independent of maternal history of varicella, in neonates born at <28 weeks of gestational age or who weighed <1000g at birth who have been significantly exposed to Varicella-Zoster Virus (VZV).**

<table>
<thead>
<tr>
<th>Grade of recommendations: National Guidelines</th>
</tr>
</thead>
</table>

| <28w GA or <1000g BW | Infectiology/VZV |

### Item 106

**Start Varicella-Zoster Immune Globulin (VZIG) 125IU IM in neonates ≥28w GA or ≥1000g BW who have been significantly exposed postnatally to Varicella-Zoster Virus (VZV), only if born to mother who has no or unkown history of varicella.**

**VZIG must be administered as soon as exposure is known and within a 72 hour period.**

<table>
<thead>
<tr>
<th>Grade of recommendations: National Guidelines</th>
</tr>
</thead>
</table>

| ≥28w GA or ≥1000g BW | Infectiology/VZV |
### Item 107

**Start**

Varicella-Zoster Immune Globulin (VZIG) 125IU IM as soon as possible, after birth or with onset of maternal illness, in term or late preterm neonates whose mother had varicella disease 5 days prior to or 2 days after delivery.

#### Grade of recommendations: Institutional Guidelines


### Item 108

**Start**

Aciclovir IV in neonates who develop systemic symptoms or severe cutaneous Varicella-Zoster disease, or who are at high risk of infection.

Infants at high risk of infection are those who did not receive Varicella-Zoster immunoglobulin (VZIG) as indicated, and/or are immunocompromised, and/or are <28 weeks’ GA at birth. Do not give oral aciclovir as absorption is unpredictable in neonates.

#### Grade of recommendations: National Guidelines


Stop Varicella-Zoster immunoglobulin (VZIG) if neonatal chickenpox has developed.

Varicella-Zoster immunoglobulin (VZIG) is of no benefit once neonatal chickenpox has developed and treatment should be discontinued.

Grade of recommendations: Institutional Guidelines


<table>
<thead>
<tr>
<th>All</th>
<th>Infectiology/VZV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Varicella-Zoster immunoglobulin (VZIG)</td>
</tr>
</tbody>
</table>
### Item 110

**Do not use prophylactic antibiotic treatment in neonates at high risk of chlamydial infection (born to mothers who have untreated chlamydia).**

Neonates born to mothers who have untreated chlamydia are at high risk of infection; however, prophylactic antibiotic treatment is not indicated, as the efficacy of such treatment is unknown. Infants should be monitored to ensure appropriate treatment if symptoms develop.

**Grade of recommendations: National Guidelines**


### Item 111

**Start erythromycin orally for 14 days in neonates with chlamydial conjunctivitis or with suspected or confirmed chlamydial pneumonia.**

Follow your institution guideline for dosage. Because the efficacy of erythromycin therapy is approximately 80%, a second course may be required, and a follow-up of infants is recommended. Neonates treated with erythromycin or azithromycin should be observed for signs and symptoms of hypertrophic pyloric stenosis.

**Grade of recommendations: National Guidelines**


Item 112

Start azithromycin as second line treatment when erythromycin is not available in neonates with chlamydial conjunctivitis or with suspected or confirmed chlamydial pneumonia.

Azithromycin suspension should be administered for 3 days. Neonates treated with erythromycin or azithromycin should be observed for signs and symptoms of hypertrophic pyloric stenosis.

Grade of recommendations: National Guidelines


All

Infectiology/Chlamydia

Item 113

Stop topical antibiotics for the treatment of chlamydial conjunctivitis in neonates.

Topical antibiotic therapy alone is inadequate for the treatment of ophthalmia neonatorum caused by chlamydia and is unnecessary when systemic treatment is administered.

Grade of recommendations: National Guidelines


All

Infectiology/Chlamydia

Topical antibiotics
### Gonorrhea

#### Definition

**Suspicion of Gonorrhea infection:**

Gonococcal ophthalmia is strongly suspected when intracellular gram-negative diplococci are identified on Gram stain of conjunctival exudate.


---

<table>
<thead>
<tr>
<th>Item 114</th>
<th>Administer 1 dose of ceftriaxone IV or IM in all neonates born to mothers who have untreated gonorrhea.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow your institution guideline for dosage. Treatment must be preceded by testing the infant for gonorrhea at exposed sites. Avoid giving ceftriaxone to premature infants till 41 weeks postmenstrual age, hyperbilirubinemic infants and those receiving calcium-containing intravenous fluids. When ceftriaxone must not be used, cefotaxime can be considered.</td>
</tr>
<tr>
<td></td>
<td><strong>Grade of recommendations: National Guidelines</strong></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Item 115</th>
<th>Administer 1 dose of ceftriaxone IV or IM in neonates with suspected or confirmed gonococcal ophthalma neonatorum or other localized gonococcal infection.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow your institution guideline for dosage. Infant should receive eye irrigations with saline solution immediately and at frequent intervals until discharge is eliminated. Avoid giving ceftriaxone to premature infants till 41 weeks total age, hyperbilirubinemic infants and those receiving calcium-containing intravenous fluids. When ceftriaxone must not be used, cefotaxime can be considered.</td>
</tr>
<tr>
<td></td>
<td><strong>Grade of recommendations: Textbook</strong></td>
</tr>
</tbody>
</table>
### Item 116

**Stop topicals antibiotics in neonates with suspected or confirmed gonococcal ophthalmia neonatorum.**

They should receive IV antimicrobial therapy and eye irrigations with saline solution immediately and at frequent intervals until discharge is eliminated. Topical antimicrobial treatment alone is inadequate and unnecessary when recommended systemic antimicrobial treatment is given. This statement does not apply to gonococcal ophthalmia neonatorum prophylaxis, which is practiced in certain medical centers by giving topical treatment at birth to all newborn infants.

**Grade of recommendations: National Guidelines**


### Item 117

**Start ceftriaxone IV or IM in neonates with disseminated gonococcal infection.**

Follow your institution guideline for dosage. Avoid giving ceftriaxone to premature infants till 41 weeks total age, hyperbilirubinemic infants and those receiving calcium-containing intravenous fluids. When ceftriaxone must not be used, cefotaxime can be considered.

**Grade of recommendations: National Guidelines**


<table>
<thead>
<tr>
<th>Item 118</th>
<th>Methicillin-Resistant Staphylococcal Aureus (MRSA) Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start</strong></td>
<td>Start vancomycin IV until bacteremia is excluded for localized Methicillin-resistant Staphylococcus aureus (MRSA) disease in preterm or very low-birthweight neonates or in more-extensive forms of the disease involving multiple sites in full-term neonates.</td>
</tr>
</tbody>
</table>
**Definition**

**Confirmed congenital infection:**
Treponema pallidum demonstrated by darkfield examination (DFE) or polymerase chain reaction (PCR) in placenta or autopsy material, exudate from suspicious lesions or body fluids, e.g. nasal discharge.

**Presumed congenital infection:**
- Children with a positive treponemal test for syphilis in combination with one or several of the following:
  - persistent rhinitis, condylomata lata, osteitis, periostitis, osteochondritis, ascites, cutaneous and mucous membrane lesions, hepatitis, hepatosplenomegaly, glomerulonephritis, haemolytic anaemia;
  - radiological abnormalities of the long bones suggestive of congenital syphilis;
  - a positive Rapid Plasma Reagin (RPR) test / Venereal Diseases Research Laboratory (VDRL) test in the cerebrospinal fluid;
  - a fourfold increase or more of the T. pallidum Passive Particle Agglutination (TPPA) / T. pallidum Haemagglutination (TPHA) titre in the child’s as opposed to the mother’s serum (both obtained simultaneously at birth);
  - a fourfold increase or more of the titre of a non-treponemal test in the child’s as opposed to the mother’s serum (both obtained simultaneously at birth);
  - a fourfold increase or more of the titre of a non-treponemal test within 3 months after birth;
  - a positive anti-treponemal IgM EIA, 19S-IgM-FTA-abs test and/or IgM- immunoblot for T. pallidum in the child’s serum;
  - a mother, in whom syphilis was confirmed during pregnancy, but who was not adequately treated either before or during pregnancy.


**Item 119**

Administer benzylpenicillin G IV, OR procaine penicillin to neonates with confirmed or presumed congenital syphilis, or born to syphilis infected mothers who have not been treated with penicillin at least four weeks prior delivery.

Follow your institution guideline for dosage.

Grade of recommendations: National Guidelines


Infectiology/Syphilis
Administer 1 dose of benzathine penicillin G IM in neonates with normal examination, born to syphilis infected mothers who have been adequately treated during pregnancy more than 4 weeks prior to delivery.

Follow your institution guideline for dosage. If mother’s nontreponemal serologic titer remained low and stable before and during pregnancy and at delivery (Venereal Disease Research Laboratory (VDRL) slide test <1:2; rapid plasma reagin (RPR) test <1:4), no treatment is required. If follow-up is uncertain, a single dose of benzathin penicillin G IM can be considered.

Grade of recommendations: National Guidelines


**Item 121**

**Ureaplasma Urealyticum Infection**

**Reassess the use of macrolides or other antibiotics for the treatment of Ureaplasma urealyticum in neonates.**

Despite in vitro susceptibility of Ureaplasma spp. to erythromycin and favorable pharmacokinetic activity, trials of erythromycin therapy in ureaplasma-colonized preterm infants have failed to demonstrated efficacy to prevent BPD or to eradicate respiratory tract colonization (C). The efficacy of azithromycin and related macrolide, clarithromycin, to prevent BPD has been assessed in single center studies of at-risk preterm infants, but the safety and optimal dosing regimens for these antibiotics have not been determined in appropriate pharmacokinetic and pharmacodynamic studies. It is currently unknown whether eradicating Ureaplasma spp. from the preterm respiratory tract with appropriate antibiotic therapy will prevent ureaplasma infection-mediated lung injury (FRN).

**Grade of recommendations: Review**

Urinary tract infection is defined here as:
1. Pyuria as determined with an “enhanced urinalysis” (hemocytometer counting chamber) of ≥10 WBC/μL;
2. A urine culture colony count of ≥10 000 CFU/mL for a single organism.

Vesico-ureteric reflux (VUR):
Grade I: urine refluxes into the ureter only;
Grade II: urine refluxes into the ureter and up to the kidney without dilation;
Grade III: urine refluxes into the ureter and kidney and causes mild dilation;
Grade IV: urine refluxes into ureter and kidney and causes dilation without twisting of the ureter;
Grade V: urine refluxes into ureter and kidney and causes significant dilation with twisting of the ureter.


Start empiric antibiotics after urine samples and cultures are collected in neonates with fever when urinary tract infection is suspected.

Follow your institution guidelines for dosage and choice of antibiotic agents.

Grade of recommendations: International Guidelines


Consider antibiotic prophylaxis after an urinary tract infection (UTI) only in neonates with grade IV-V vesico-ureteric reflux.

Antibiotic prophylaxis in order to avoid recurrent UTI is no longer routinely recommended after a UTI but may still be considered when a child is known to have a grade IV or V VUR, or a significant uro-logical anomaly. Grade IV-V are defined as urine reflexes into ureter and kidney and causes dilatation with or without twisting of the ureter.

**Grade of recommendations: International Guidelines**


**Suspicion of Pertussis infection:**
Pertussis should be suspected (regardless of vaccination status or wheezing) in the following patients (see 'Clinical suspicion' above):

- Infants <4 months with a cough illness, usually without significant fever, who have:
  - Cough that is not improving (of any duration); the cough may or may not be paroxysmal (movie 1)
  - Rhinorrhea in which the nasal discharge remains watery
  - Apnea, seizures, cyanosis, vomiting, or poor weight gain
  - Leukocytosis with lymphocytosis (WBC count ≥20,000 cells/microL with ≥50 percent lymphocytes)
  - Pneumonia


---

**Start azithromycin oral daily for 5 days in neonates with suspected or confirmed pertussis infection, or in those in close contact with confirmed and contagious cases of pertussis.**

Follow your institution guideline for dosage. A person is contagious when < 21 days of cough and < 5 days effective antibiotics. Neonates on macrolide should be monitored for infantile hypertrophic pyloric stenosis (IHPS).

---

**Grade of recommendations: National Guidelines**


### Item 125

**Start isoniazid prophylaxis orally in neonates born to mothers with tuberculosis (TB), or those in close contact with people with smear-positive pulmonary or laryngeal TB who have not had at least 2 weeks of anti-tuberculosis treatment.**

Prophylaxis for babies born to mothers with active TB is 9 months, and 2-3 months in those born to mothers with inactive TB, if the infant remains asymptomatic. Infants exposed postnatally should be treated 2-3 months after last exposure, if the infant remains asymptomatic. Follow your institution guideline for dosage.

**Grade of recommendations: National Guidelines**


### Item 126

**Start anti-tuberculosis treatment in neonates with congenital tuberculosis or postnatal tuberculosis primary pulmonary disease.**

Follow your institution guideline for dosage.

**Grade of recommendations: Textbook**


### 10. ENDOCRINOLOGY

**Metabolic Bone Disorder (MBD)**

#### Definition

**Metabolic Bone Disorder**

Decreased bone mineral content relative to the expected level of mineralization for a fetus or infant of comparable size or gestational age seen in conjunction with biochemical and/or radiographic changes.


#### Risk factors for Metabolic Bone Disorder

- <32 weeks’ gestation or <1500 g birth-weight
- Male gender
- Inadequate nutrition
  - Suboptimal intake
    - Enteral feeds with low mineral content/bioavailability (unfortified expressed breast milk, term formula given to a preterm infant)
- Phosphorus deficiency (primary nutritional reason)
- Vitamin D deficiency
- Prolonged total parenteral nutrition
- Chronic use of drugs that increase mineral excretion (diuretics, dexamethasone, sodium bicarbonate)
- Lack of mechanical stimulation e.g. sedation/paralysis
- Bronchopulmonary dysplasia
- Cholestatic jaundice
- Short gut syndrome (malabsorption of vitamin D and Ca)


#### Item 127

**Administer calcium, phosphate and vitamin D in preterm infants <32 weeks of gestational age or <1500g or infants at risk of metabolic bone disorders.**

When receiving enteral feed, neonates should be given a fortifier (in breastfed infants) or preterm formula with calcium (3.5-5.5 mmol/kg/day) and phosphate (2.5-4.5 mmol/kg/day). If parenteral nutrition is needed, use parenteral nutrition with optimised calcium and phosphate content (Ca 1.8 mmol/kg/day and PO4 1.4 mmol/kg/day) and vitamin D 160-400 IU/kg/day. Maximal mineral accretion rates have been reported with Ca/PO4 (mol/mol) ratio 1.3.

In neonates with biochemical features found in metabolic bone disease, aim for the upper end of the recommended range of calcium and phosphate intake to prevent fractures.

#### Grade of recommendations: Review


Administer the maximal recommended doses of calcium, phosphate and vitamin D to prevent fractures in neonates with biochemical features of metabolic bone disease.

Recommended range are:
When receiving enteral feed, neonate should be given fortifier (for breastfed infant) or preterm formula with calcium (3.5-5.5 mmol/kg/day) and phosphate (2.5-4.5 mmol/kg/day). Do not give Ca and PO4 at the same time because they may precipitate; so give at alternate feeds.
If parenteral nutrition is needed, use parenteral nutrition with optimised calcium and phosphate content (Ca 1.8 mmol/kg/day and PO4 1.4 mmol/kg/day) and vitamin D 160-400 IU/kg/day. Maximal mineral accretion rates have been reported with Ca/PO4 (mol/mol) ratio 1.3.

Grade of recommendations: Institutional Guidelines
Royal Prince Alfred Hospital Care Newborn. Metabolic bone disease. Sydney Local Health District - New South Wales government.

Stop steroids and furosemide as soon as possible in neonates at risk of metabolic bone disorder.

In the primary prevention and treatment strategy for MBD, limiting the prolonged exposure to commonly prescribed medications that further reduce mineral stores (e.g. loop diuretics and methylxanthines) or increase bone resorption (e.g. glucocorticoids) is equally important to optimizing nutrition.

Grade of recommendations: National Guidelines
**Start levothyroxine (L-T4) immediately in neonates with thyroid function test (TFT) that results in either a free T4 (FT4) concentration below norms for age or a venous TSH concentration > 20 mIU/L.**

TFT is normally performed when capillary TSH concentration from blood obtained on neonatal screening was elevated; therefore this recommendation assumes a high capillary TSH value. Imaging should never be allowed to delay the initiation of treatment. Recommended treatment is levothyroxine (L-T4), given at an initial oral dose of 10 –15 μg/kg/day. Infants with very low total T4 or free T4 should be treated with the highest initial dose. Any change in source of the L-T4 (brand) or in formulation (liquid vs tablets) requires retitration of the dose. If intravenous treatment is necessary the dose should be no more than 80% of the oral dose. The dose should then be adjusted according to TSH and FT4 levels.

**Grade of recommendations: International Guidelines**


Hyperglycemia

There is no established definition of hyperglycemia. However, start management if:
- two blood sugars are ≥14 on 2 occasions measured at least 2 hr apart
or
- blood sugars are ≥12 on 2 occasions measured at least 2 hr apart with evidence of significant glycosuria (positive on the urine dipstick).


Item 131

Decrease glucose intake if necessary and decrease or stop drugs that worsen hyperglycemia, in neonates with hyperglycemia.

If glucose delivery rate >10 mg/kg/min, decrease glucose in increments to 6–10 mg/kg/min. If on TPN, 8–10 mg/kg/min is acceptable. Medications that can worsen hyperglycemia include corticosteroids and phenytoin.

Grade of recommendations: Textbook


### Item 132

**Start insulin only in patients with persistent hyperglycemia when other methods of glucose control have failed.**

Other methods of glucose control include decrease of glucose infusion rates, stop of medications predisposing patients to hyperglycemia, and correction of underlying causes of hyperglycemia (i.e., sepsis). Starting dose of insulin is usually 0.05 units/kg/hr, then adjusted according to requirements. Do not include insulin in the total daily fluid intake - it should be titrated on top of the prescribed fluid intake. Monitor the blood glucose concentration, initially once every 2 hours, and once stable at least once every 8 hours. Aim for a blood glucose concentration between 6 and 10 mmol/L.

To prevent hypoglycaemia in neonate on insulin:
- 6-8 mmol/L and stable -> maintain insulin infusion
- 6-8 mmol/L with a moderate decrease: reduce insulin infusion rate to 50% of present rate
- <6 mmol/L or 6-8 mmol/L with a rapid decrease: stop infusion

### Grade of recommendations: National Guidelines


### Item 133

**Do not provide high glucose infusion rates to prevent hypoglycemia in neonates receiving parenteral nutrition.**

Excess glucose delivery should be avoided to maintain optimal blood glucose concentrations in neonates receiving parenteral nutrition as this may lead to hyperglycemia.

### Grade of recommendations: National Guidelines

Do not use early insulin therapy in neonates at risk of hyperglycemia.

The use of early insulin therapy to prevent hyperglycemia is not recommended. There has been substantial research regarding the use of early, continuous insulin infusion to prevent hyperglycemia in the neonate. While a number of small studies suggest a benefit, other larger studies have raised significant concerns regarding this practice. Specifically, a large RCT was terminated early due to increased incidence of hypoglycemia and mortality in the early continuous insulin infusion group. A recent Cochrane review also determined that there is insufficient evidence to recommend early, continuous insulin infusion.

Grade of recommendations: A

Symptoms of hypoglycemia in newborns include: irritability, tremors, jitteriness, exaggerated Moro reflex, high-pitched cry, seizures, lethargy, floppiness, cyanosis, apnea, poor feeding.

Neonates at increased risk of hypoglycemia:
1. Symptoms of hypoglycemia
2. Large for gestational age (even without maternal diabetes)
3. Perinatal stress
   a. Birth asphyxia/ischemia; cesarean delivery for fetal distress
   b. Maternal preeclampsia/eclampsia or hypertension
   c. Intrauterine growth restriction (small for gestational age)
   d. Meconium aspiration syndrome, erythroblastosis fetalis, polycythemia, hypothermia
4. Premature or postmature delivery
5. Infant of diabetic mother
6. Family history of a genetic form of hypoglycemia
7. Congenital syndromes (eg, Beckwith-Wiedemann), abnormal physical features (eg, midline facial malformations, microphallus)

Persistent hypoglycemia
Hypoglycemia that persists or occurs for the first time beyond the first 3 days of life.


Item 135
Start IV glucose infusion in asymptomatic neonates with serum glucose level of <2.6 mmol/L if increased enteral caloric intake is not effective.

Start with an initial glucose infusion regime of 5.5 mg/kg/min. Infants with very low glucose levels, particularly those with levels less than 1.8 mmol/L, should be managed with some expediency, confirming response to intervention in a timely fashion (a response to intravenous interventions should occur within 30 min). Breastfeeding may be continued without risk of overhydration because the volume of colostrum is small. Blood glucose levels should be checked frequently until interventions result in stable glucose levels of 2.6 mmol/L or higher. In neonates with persistent hypoglycemia, consider investigation, consultation and pharmacological intervention if target blood glucose levels are not achieved by intravenous glucose.

Grade of recommendations: Institutional Guidelines


### Start IV glucose infusion immediately in symptomatic neonates with glucose levels <2.6 mmol/L.

Because severe, prolonged, symptomatic hypoglycemia may result in neuronal injury, prompt intervention is necessary for infants who manifest clinical signs and symptoms. At-risk infants with glucose levels less than 1.8 mmol/L on one occasion (assuming one effective feed), or repeatedly less than 2.6 mmol/L, require intervention (C). There should be concurrent investigation and management of the underlying cause. Breastfeeding may be continued without risk of overhydration because the volume of colostrum is small. Blood glucose levels should be checked frequently until interventions result in stable glucose levels of 2.6 mmol/L or higher. In neonates with persistent hypoglycemia, consider investigation, consultation and pharmacological intervention if target blood glucose levels are not achieved by intravenous glucose.

**Grade of recommendations: National Guidelines**

### Item 137

**Check the possible milk transfer of drugs taken by mothers to breastfed neonates, and monitor for potential adverse drug effects.**

Different references can be consulted or refer to a specialist (clinical pharmacist or pharmacologist). For example, several reported cases of codeine toxicity, in breastfed neonates (including death) have been published. Keep in mind that drugs given to the breastfeeding mother can also interact with the treatment of the neonate. Here are examples of common sources of information about drugs and lactation:

- **Swiss teratogen information service**: [http://www.swisstis.ch/](http://www.swisstis.ch/)
- **Centre de référence sur les agents tératogènes** (in french): [www.lecrat.org](http://www.lecrat.org)

**Grade of recommendations: D**
Check changes in drug effect when initiating strong inhibitors or inducers of the cytochrome P450 and/or P-glycoprotein.

Although difficult to predict, modification of plasma concentration may occur when initiating strong inhibitors or inducers of the cytochrome P450 and/or P-glycoprotein. Examples of strong inhibitors and inducers used in neonates are:

**Inhibitors:** erythromycin, fluconazole.

**Inducers:** phenobarbital, phenytoin, rifampicin.

Keep in mind that drugs given to the breastfeeding mother can also interact with the treatment of the neonate, if transfer to milk occurs.

Here are examples of common sources of information about drug interactions:

- Theriaque: http://www.theriaque.org/

**Grade of recommendations: D**


### Item 139

**Do not use ceftriaxone in neonates who are being, or who have recently been given any IV fluids that contain calcium (such as TPN or Ringer Lactate)**

Precipitation may occur even when the two products are administered in different tubes and could be potentially lethal. Ceftriaxone can also induce kernicterus in the neonate by displacing bilirubin from plasmatic proteins, and its use should be avoided when possible.

**Grade of recommendations: Manufacturer**


### Item 140

**Do not use trimethoprim - sulfamethoxazole in neonates.**

Trimethoprim-sulfamethoxazole is contra-indicated in neonates. Sulphonamides can induce kernicterus in the neonate by displacing bilirubin from plasmatic proteins.

**Grade of recommendations: National Guidelines**


Check excipients contained in prescribed drug formulations administered orally or parenterally since they can be harmful and responsible for adverse events in neonates, due to immature metabolism.

Benzyl alcohol must not be given to premature babies or neonates due to risks of serious adverse effects (gaxping syndrome and deaths have been reported). Propylenglycol must not be administrated to neonates at a dose higher than 1 mg/kg/day because it could lead to metabolic acidosis. Excipients identified as known to be harmful to neonates should be avoided as much as possible. The sum of methyl-, ethyl- and propylparaben should not be >10mg/kg/day in oral drugs and propylparaben oral daily intake should not be >2mg/kg/day. Other excipients known to be harmful in neonates are: polysorbate 80, sodium benzoate, benzalkonium chloride, saccharin sodium, sorbitol and ethanol. High dose and long term use should be avoided when possible.

Grade of recommendations: D


