

Jaundice: Decoding the Data and Frontline Management
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Normal Physiologic Jaundice

60% newborn infants in the US are diagnosed with jaundiced
Often seen well in the sclera (whites of the eyes)—first to appear and last to leave
Bilirubin as an antioxidant protects human infants while all physical systems begin functioning.
NOT caused by immature liver unless infant is premie or immature
Normal breakdown of extra red blood cells needed by fetus and not needed after birth
Excretion of bilirubin facilitated by suckling (peristalsis) and protein (Colostrum)

Ethnic/genetic norms

Asians, Middle Eastern, Native American; peaks at 10-12 on day 5-9, gradually comes down
Caucasian; peaks at about day 2-5
African American; peaks at about day 2-5

Importance of responsible presentation of jaundice to parents to avoid “sick-baby syndrome”

“Your baby had just the right amount of red blood cells in the womb. But he doesn’t need that much now. Your baby is not sick; his body is doing what it is supposed to do. All healthy babies have an elevated bilirubin and it now needs to be excreted.”

Supplementation with ABM

Supplementation with formula will usually lower bili numbers but with resumption of breastfeeding there is a rebound effect. Such supplementing does not change a baby’s health status and is not recommended unless baby’s numbers are dangerously high. If baby is at health risk he should be seen by a specialist and not treated with non-breastmilk supplement just to reduce numbers.

For optimal health newborn infants need to feed 8-12 times in 24 hours.

Bilirubin levels correlate inversely with number of feedings over the first 3 days.

Average number of feeds per day	Day 3 Bilirubin Level
6	11
6.8	9.3
10.1	6.5
12	5

WALC presentation by Pat Gima, IBCLC