Small for Gestational Age (SGA) Clinical Practice Guideline - Newborn Nursery

General Information
This clinical practice guideline addresses the care of the infants in the newborn nursery who are small for gestational age. By definition, SGA is an infant under the 10th percentile for weight, based on gestational age. Most, but not all, of these infants will be less than 2.5 kg. These infants are most commonly at increased risk for the following issues:

Thermoregulation  Sepsis/Respiratory Risks  Feeding Difficulties  Hypoglycemia  Polycythemia

Consider underlying causes for SGA when ordering further laboratory and imaging studies (see box below).

Admission Criteria:
a. Infants < 2.0 kg will be managed initially in the transitional nursery for monitoring and further recommendations.
b. Infants admitted to the transitional nursery or NICU will be transferred to the newborn nursery under the discretion of the nursing staff, flow coordinator, as well as the attending physicians.
c. SGA infants will remain on vital signs q 4 hours throughout the first 72 hours of admission.

Discharge Criteria:
a. All SGA infants in the newborn nursery will demonstrate the following prior to discharge:
   - Temperature stability
   - Stable blood glucose levels
   - Adequate feeding
b. Outpatient follow-up is recommended within 2 days of discharge with PCP and/or home Visiting Nurse (VNA) to assess weight gain, feeding, temperature stability, and jaundice. Priority status for VNA referral to be noted on the form faxed to the office.
c. Car seat angle test if < 37 weeks gestational age, < 2.5 kg at birth, sepsis/respiratory risk factors present, or other parameters according to policy NPM 12D.

Thermoregulation
a. Infants less than 2.0 kg remain in an isotope for 48 hours
b. Initiate and maintain skin-to-skin contact with parent to facilitate temperature regulation of the infant
c. Place in an isotope when not skin-to-skin until infant able to thermoregulate
d. For infants 2.0 - 2.5 kg, consider isotope for temperature regulation for 48 hours
e. Vitals should be no less frequent than q 4 hours

Feeding Difficulties/Hypoglycemia
a. Initiate early feedings to stabilize blood glucose levels
b. Consider supplemental feeds q 3 hours
c. Screen blood glucose levels per “Newborn Hypoglycemia Clinical Algorithm” – recognize these infants are at highest risk for hypoglycemia (much like IDDM)
d. Ensure good enteral intake.
e. Supplement feedings (via gavage) if weight loss exceeds more than 3% per day or more than 10% of birth weight prior to discharge

Jaundice: Adhere to “Hyperbilirubinemia Clinical Practice Guideline” for screening of jaundiced patients utilizing Bhutani nomograms.

Sepsis/Respiratory Risks
a. Screen for infection per “GBS and Suspected Sepsis Clinical Practice Guideline”
b. Monitor cardio-respiratory status until stable for 48 hours if ≤ 35 6/7 weeks gestation

For breast-feeding babies:
a. Offer breast whenever infant cues to feed
b. Lactation consult to see mother within 24 hrs
c. Instruct mother to initiate pumping within 4 - 6 hours of delivery

For bottle-feeding babies:
Offer bottle whenever infant cues to feed

Other Labs/Imaging for evaluation and management of SGA infants depends on history and PE findings and may include:
a. Ongoing blood glucose monitoring beyond protocol if poor feeding or temperature instability noted
b. CBC for risk of polycythemia
c. CBC, CRP for risk of sepsis
d. Viral cultures (TORCH)
e. Head US or head CT/ MRI
f. Karyotype/DNA analysis

REFERENCES

Algorithms are not intended to replace providers’ clinical judgment or to establish a single protocol. Some clinical problems may not be adequately addressed in this guideline. As always, clinicians are urged to document management strategies.

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