

DEFINITION

- The skin has turned a yellow color
- At higher bilirubin levels, the whites of the eyes also turn yellow
- Covers jaundice in newborn to age 3 months (90 days)
- Included: Home phototherapy questions are also covered

INITIAL ASSESSMENT QUESTIONS

1. SKIN COLOR: "What color is the jaundice?" "How deep is the color?" "Is your baby a lot more yellow than when last seen?"
2. EYE COLOR: "Are the whites of the eyes (sclera) yellow?"
3. SEVERITY and LOCATION: "What part of the body is jaundiced?" "Does it involve the legs?"
 - MILD jaundice: Face only
 - MODERATE jaundice: Trunk involved (chest and/or abdomen)
 - SEVERE jaundice: Legs involved or entire body surface
4. ONSET: "On what day of life did you first notice your newborn was jaundiced?" (Days)
5. BILIRUBIN LEVEL: "Did the hospital or office tell you your baby's discharge bilirubin level?" If so, "What was it?" (Note: includes either serum or transcutaneous measurements)
6. SYMPTOMS: "Does your baby have any other symptoms?" If so, ask: "What are they?"
7. OUTPUT: "How many poops has your baby passed in the last 24 hours?" (Normal: 3 or more per day)
"How many wet diapers have there been in the last 24 hours?"
8. FEEDING: "How is feeding going?" "How strong a feeder is your baby?"
9. BABY'S APPEARANCE: "How is your baby acting?"

- Author's note: IAQ's are intended for training purposes and not meant to be required on every call.

TRIAGE ASSESSMENT QUESTIONS

Call EMS 911 Now

Unresponsive and can't be awakened

R/O: sepsis

Signs of shock (very weak, limp, not moving, gray skin, etc.)

Sounds like a life-threatening emergency to the triager

See More Appropriate Protocol

Age more than 3 months (90 days)

Go to Protocol: Jaundice - Child or Teenager (Pediatric)

Go to ED Now

Age < 12 weeks with fever 100.4° F (38.0° C) or higher by any route (rectal reading preferred)

R/O: sepsis, UTI

Go to ED/UCC Now (or to Office Now per Practice Policy)

Newborn < 4 weeks starts to act sick or abnormal in any way (e.g., decrease in activity)

R/O: sepsis

Low temperature < 96.8° F (36.0° C) rectally that doesn't respond to warming

R/O: sepsis

Baby sounds very sick or weak to triager

R/O: sepsis

Go to Office Now

Feeding poorly (e.g., little interest, poor suck, doesn't finish)

Signs of dehydration (very dry mouth, sunken fontanelle, no urine in 8 hours)

Whites of the eye (sclera) have turned yellow

Reason: bilirubin level probably over 15

Skin looks deep yellow or orange or legs are jaundiced

R/O: high bilirubin level

Jaundice worse than when last seen

Callback by PCP Within 1 Hour

Caller requesting bilirubin lab results

New bilirubin lab results seen by caller and requests treatment plan

See in Office Today

Jaundice spreads to abdomen (belly)

HIGH-RISK baby for severe jaundice (preterm < 37 weeks or ABO or Rh problem or cephalohematoma or sib needed bili-lights or Asian race, etc.)

Began during the first 24 hours of life

R/O: hemolytic jaundice

Mother concerned the baby is not getting enough breastmilk

R/O: elevated bilirubin due to poor milk intake

Good-sized yellow, seedy stools per day are < 3 (Exception: breastfed and before 5 days of life)

R/O: elevated bilirubin due to poor milk intake

Day 2 to 4 of life and no stool in over 24 hours and breastfed

Wet diapers per day are < 6 (Exception: 3 wet diapers/day can be normal before 5 days of life if breastfed)

R/O: elevated bilirubin due to poor milk intake

Day 2 to 4 of life and no urine in over 8 hours

Discharged before 48 hours of life and 4 or more days old and hasn't been examined since discharge

Reason: AAP recommends re-check

Caller is concerned about the degree of jaundice

See in Office Within 3 Days

Jaundice begins or reappears after 7 days old

Reason: not physiological jaundice

Stools (BMs) are white, pale yellow or light gray

R/O: neonatal hepatitis, biliary atresia

Jaundice is not gone after 14 days old

R/O: breastmilk jaundice, liver disease, UTI

Triager thinks child needs to be seen for non-urgent problem

Caller wants child seen for non-urgent problem

Home Care

Mild jaundice of newborn

Home phototherapy, questions about

Home Care Advice

Mild Jaundice Treatment

1. **Reassurance and Education - Mild Newborn Jaundice:**
 - Jaundice means the skin has turned yellow.
 - Bilirubin is the pigment that turns the skin yellow.
 - Bilirubin comes from the normal breakdown of old red blood cells.
 - The liver normally gets rid of bilirubin. But at birth, the liver may be immature.
 - Half of babies have some jaundice. Usually, it is mild and doesn't need any treatment.
 - The first place for jaundice to appear is on the face.
 - Jaundice that only involves the face is harmless.
 - The level of bilirubin that is harmful is around 20. Reaching a level this high is rare.
 - High levels need to be treated with bili-lights. That's why your doctor checks your baby's bilirubin levels until it becomes low.
2. **Bottle Feed More Often:**
 - If bottle fed, increase the frequency of feedings.
 - Try for an interval of every 2 to 3 hours during the day.
3. **Breastfeed More Often:**
 - If breastfed, increase the frequency of feedings.
 - Nurse your baby every 1½ to 2 hours during the day.
 - Don't let your baby sleep more than 4 hours at night without a feeding.

- Goal: at least 10 feedings every 24 hours.

4. **Infrequent Stools Means Your Baby Needs More Milk:**

- Breastmilk and formula help carry bilirubin out of the body. Therefore, good feedings are important for bringing down the bilirubin level.
- In the first month, keep track of how many stools are passed daily. The number of stools reflects how much milk your baby is getting.
- If your baby is 5 days or older, they should have at least 3 stools daily. If stooling less than that, it usually means your baby needs more to eat.
- Try to increase the number and amount of feedings per day.
- If you are having any trouble with breastfeeding, consult a lactation expert. Also, schedule a weight check.
- Caution: Stimulating the anus to increase the release of stools is not helpful for reducing the bilirubin level.

5. **Expected Course:**

- Physiological jaundice peaks on day 4 or 5 and then gradually disappears over 1-2 weeks.

6. **Judging Jaundice:**

- Jaundice starts on the face and moves downward. Try to determine where it stops.
- View your baby unclothed in natural light near a window.
- Press on the yellow skin with a finger to remove the normal skin tone.
- Then try to assess if the skin is yellow before the pink color returns.
- Move down the body, doing the same. Try to assess where the yellow color stops.
- Jaundice that only involves the face is harmless.
- As it involves the chest, the level is going up.
- If it involves the whites of the eyes, abdomen, or legs, the bilirubin level needs to be checked.

7. **Call Back If:**

- Jaundice becomes worse
- Eyes, belly or legs become yellow
- Feeding poorly or weak suck
- Baby starts to act sick or abnormal
- Jaundice not gone by day 14

Home Phototherapy Questions

1. **Bili-blanket - How it works:**

- A bili-blanket is a type of phototherapy that can be used at home. It must be prescribed by your baby's doctor. The light emitted from the blanket helps to breakdown the bilirubin in the skin. The blanket is connected to a machine by a cable. The machine is then plugged into a wall outlet.
- Safety: The bili-blanket system uses pure light energy so no electricity or heat is generated near your baby. Follow your manufacturer's instructions on eye protection.

2. **Bili-blanket - How to put it on:**

- The fiberoptic blanket is inserted into a soft cover so it doesn't irritate the baby's skin.
- It emits light from one side only. The bright side is placed directly on the baby's skin and wraps the torso area.
- You can put the baby's clothes over the bili-blanket and swaddle with a regular blanket to keep the newborn warm.

3. **Bili-blanket - When to Wear it:**

- The blanket should be left on when holding, feeding, or sleeping.
- The only time it's necessary to remove it and turn it off is during bathing.
- In fact, the blanket should be worn as much as possible to be effective.

4. **Alternate Disposition - Call the Home Health Agency:**
 - These babies are usually followed by a home health agency. The home health nurse can assess your baby in the home and provide education. They usually require daily bilirubin tests and weights.
 - If you have questions about medical equipment being used in your home, the home health agency may be able to answer them over the phone as well.
5. **Call Back If:**
 - Jaundice becomes worse
 - Feeding poorly or weak suck
 - Your baby starts to act sick or abnormal

FIRST AID

N/A

BACKGROUND INFORMATION

Recognizing Jaundice

Sometimes callers aren't certain if the newborn's skin is jaundiced. The color of the sclera is essential in assessing children with darkly pigmented skin. If the sclera are white, the bilirubin level is not worrisome. If the sclera are yellow, the level may be above 15 ml/dL and it needs to be checked.

Bilirubin Level Severity By Parent's Report of Location

- The following rating scale is one factor used for phone assessment in this guideline.
- **Mild** jaundice: Face only. Don't need to be seen.
- **Moderate** jaundice: Trunk involved (chest and/or abdomen). If the caller thinks the jaundice is worse than when last checked, these newborns need to be brought in for a level.
- **Severe** jaundice: Legs involved or entire body surface. Newborns with severe jaundice all need to be referred in for a bilirubin level now. The bilirubin level is high if the whites of the eyes (sclera) turn yellow.
- These zones of jaundice probably relate to differences in capillary perfusion and skin temperature.

Bilirubin Measurement

- *Total serum bilirubin (TSB)*: This is a blood test. It is still considered the "gold standard" and true measurement of the bilirubin. It is done to determine whether babies need phototherapy or not.
- *Transcutaneous bilirubin (TcB)*: This is a non-invasive way to estimate the bilirubin level. A bilirubinometer is placed on the skin and measures the amount of bilirubin present in the extravascular tissue. It is not a substitute for TSB, but it can be used for screening to provide an estimate of the TSB value. If a baby is felt to be at risk for developing clinically significant hyperbilirubinemia, a TSB should be done. The TcB level is not reliable in babies who have received phototherapy.

Causes of Jaundice

Physiological Jaundice (50% of newborns)

- Onset 2 to 3 days of age
- Peaks day 4 to 5, then improves
- Disappears 1 to 2 weeks of age

Breastfeeding or Suboptimal Intake Jaundice (5 to 10% of breast-fed newborns)

- Due to inadequate intake of breastmilk
- Pattern similar to physiological type
- Also causes poor weight gain

Breastmilk Jaundice (10% of breast-fed newborns)

- Due to substance in breastmilk which blocks removal of bilirubin
- Also called prolonged unconjugated hyperbilirubinemia jaundice.
- Onset 4 to 7 days of age
- Lasts 3 to 12 weeks
- Breastmilk intake and weight gain are normal
- Not harmful

Rh and ABO Blood Group Incompatibility

- Onset during first 24 hours of life
- Can reach harmful levels

Liver Disease (rare)

- White or pale stools suggest biliary atresia or other obstructive liver disease as the cause of the jaundice.

Normal Prolonged Jaundice in Breastfed Babies

- Also called prolonged unconjugated hyperbilirubinemia jaundice.
- At 3 weeks of age, 43% of breastfed newborns have a bilirubin level over 5 mg/dL, and 34% were clinically jaundiced.
- At 4 weeks of age, 34% of breastfed newborns have a bilirubin level over 5 mg/dL, and 21% were clinically jaundiced.
- This new data should help with reassuring mothers and HCPs that this is normal and usually babies don't require any lab tests.
- Reference: Maisels et al, Pediatrics 2014

Scleral Icterus: a Marker for Significant Bilirubin

- A 2013 study from University of Pittsburgh Department of Pediatrics (Azzuqa, et al) found that scleral icterus detected by the parent or HCP is a marker for bilirubin levels above 15 mg/dL.
- This finding warrants a bilirubin test.
- None of the newborns with bilirubin levels of 10-15 mg/dL had scleral icterus.

Risk Factors for Severe Jaundice

- Onset within first 24 hours of life
- Blood type incompatibility (Mother is type O or Rh negative)
- Preterm: Gestational age less than 37 weeks (Preterms are 5 times more likely to have bilirubin levels over 12 than 40 week newborns)
- Sibling required phototherapy
- Bruising from birth trauma (e.g., cephalohematoma)
- Breastfeeding, especially if firstborn and feeding not going well. Newborns discharged on Thursday or Friday are at highest risk, because they need to be seen on the weekend for a recheck

of their jaundice (and sometimes that is overlooked).

- Asian race: Bilirubin levels over 12 occur in 23% of Asian babies, 12% of whites and 4% of African-Americans
- Recent phototherapy
- Caller mentions last bilirubin level was in "high-risk" zone

Kernicterus Prevention

- Kernicterus (bilirubin encephalopathy) is the most serious complication of high bilirubin levels
- Early symptoms are lethargy, hypotonia, poor suck and high-pitched cry
- The US kernicterus registry reported 61 cases in term and near-term healthy newborns in 8 years (Johnson 2002). Currently over 120 cases (2007).
- Bilirubin levels 22-48; 31% idiopathic, 31% G6PD, 10% hematomas
- Breastfed: 59 of 61 (increased risk for dehydration and malnutrition) (97%)
- Sequelae over 90% at 18 mo (cerebral palsy, developmental delays, hearing loss)
- Lapses in follow-up care: Only 28% were given an early follow-up appointment within 2-3 days of discharge. (AAP Practice Parameter 1994 and 2004 recommends any newborn discharged before 48 hours needs a check-up within 2-3 days of discharge for jaundice, feeding behavior, weight, hydration, etc.)
- Errors in telephone care: Mothers who phoned their doctor's office for jaundice, drowsiness, poor feeding, etc. received repeated reassurance rather than being seen

Biliary Atresia and Other Cholestatic Etiologies: Detection

- Current standard of care: HCPs order direct and indirect bilirubin lab tests on any baby who is still jaundiced at 2 weeks of age
- Direct (conjugated) bilirubin level is Abnormal if greater than 1.0 mg/dl
- Evaluation: referral to pediatric liver specialist
- Stools: Many of these babies also have pale, clay-colored stools

Expert Reviewer

- Elizabeth Thilo, MD; Neonatologist; Children's Hospital Colorado, Aurora, Colorado
- The author is extremely grateful for this critical review.

REFERENCES

1. American Academy of Pediatrics, Subcommittee on Neonatal Hyperbilirubinemia Neonatal jaundice and kernicterus. Pediatrics. 2001;108:763-764
2. Azzuqa A, Watchko JF. Scleral (conjunctival) icterus in neonates: A marker of significant hyperbilirubinemia. E-PAS (Pediatric Academic Societies) 2013; 3841.708
3. Bhutani V, Johnson L and Keren R. Treating acute bilirubin encephalopathy-before it's too late. Contemp Pediatr. 2005;22(5):57-74.
4. Bhutani VK, Wong RJ, Turkewitz D, et al. Phototherapy to Prevent Severe Neonatal Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation: Technical Report. Pediatrics. 2024;154(3):e2024068026.
5. Brumbaugh D, Mack C. Conjugated hyperbilirubinemia in children. Pediatr Rev. 2012;33(7):291-302.

6. Burke BL, Robbins JM, Bird TM, et al. Trends in hospitalizations for neonatal jaundice and kernicterus in the United States, 1988-2005. *Pediatrics*. 2009;123:524-532.
7. Chang PW, Kuzniewicz MW, McCulloch CE, et al. A clinical prediction rule for rebound hyperbilirubinemia following inpatient phototherapy. *Pediatrics*. 2017 Mar;139(3). pii: e20162896.
8. Chen YJ, Yeh TF, Chen CM. Effect of breast-feeding frequency on hyperbilirubinemia in breast-fed term neonate. *Pediatr Int*. 2015;57(6):1121-1125.
9. Chiu A. Unconjugated hyperbilirubinemia. In: Moyer V, Davis RL, Elliott E, et al, eds. *Evidence Based Pediatrics and Child Health*. London, England: BMJ Publishing Group; 2000. p. 306-312
10. Dixit R and Gartner LM. The jaundiced newborn: Minimizing the risks. *Contemp Pediatr*. 1999;16(4):166-183.
11. Flaherman VJ, Maisels MJ; Academy of Breastfeeding Medicine. ABM Clinical Protocol #22: Guidelines for Management of Jaundice in the Breastfeeding Infant 35 Weeks or More of Gestation-Revised 2017. *Breastfeed Med*. 2017 Jun;12(5):250-257.
12. Gartner LM, Herrarias CT, Sebring RH. Practice patterns in neonatal hyperbilirubinemia. *Pediatrics*. 1998;101:25-31.
13. Gartner LM. Neonatal jaundice. *Pediatr Rev*. 1994;15:422-432.
14. Kemper AR, Newman TB, Stlaughter JL, et al. Clinical practice guideline revision: Management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. *Pediatrics*. 2022 Sep 1;150(3):e2022058859.
15. Keren R, et al. Visual assessment of jaundice in newborns often inaccurate. *Arch Dis Child Fetal Neonatal Ed*. 2009;94:F317-F322.
16. Kramer LI. Advancement of dermal icterus in the jaundiced newborn. *Am J Dis Child*. 1969;118:454.
17. Kuzniewicz MW, Li SX, McCulloch CE, et al. Predicting the need for phototherapy after discharge: update for 2022 phototherapy guidelines. *Pediatrics*. 2022 Sep 1;150(3):e2022058020.
18. Kuzniewicz MW, Wickremasinghe AC, Wu YW, et al. Incidence, etiology, and outcomes of hazardous hyperbilirubinemia in newborns. *Pediatrics*. 2014 Sep;134(3):504-509.
19. Maisels MJ, Clune S, Coleman K, et al. The natural history of jaundice in predominantly breastfed infants. *Pediatrics*. 2014 Aug;134(2):e340-345.
20. Maisels MJ, McDonagh AF. Phototherapy for neonatal jaundice. *N Engl J Med*. 2008;358:920-928.
21. Maisels MJ. Neonatal jaundice. *Pediatr Rev*. 2006;27(12):443-454.
22. Maisels MJ. Jaundice in a newborn. *Contemp Pediatr*. 2005;22(5):34-54.
23. Maisels MJ. Transcutaneous bilirubin measurement: does it work in the real world? *Pediatrics* 2015;135(2):364-366.
24. Moyer VA, Ahn C, Sneed S. Accuracy of clinical judgment in neonatal jaundice. *Arch Pediatr Adolesc Med*. 2000;154:391-394.

25. Palmer HR, Clanton M, Ezhuthachan S, et al. Applying the 10 simple rules of the institute of medicine to management of hyperbilirubinemia in newborns. *Pediatrics*. 2003;112(6):1388-1393.

26. Pan DH, Rivase Y. Jaundice: newborn to age 2 months. *Pediatr Rev* 2017;38(11):499-510.

27. Riskin A, Tamir A, Kugelman A, et al. Is visual assessment of jaundice reliable as a screening tool to detect significant neonatal hyperbilirubinemia? *J Pediatr*. 2008;152:782-786.

28. Romero HM, Ringer C, Leu MG, et al. Neonatal jaundice: Improved quality and cost savings after implementation of a standard pathway. *Pediatrics*. 2018 Mar;141(3). pii: e20161472.

29. Slusher TM, Abdulkadir I, Owa JA. Relevance of the 2022 American Academy of Pediatrics hyperbilirubinemia guidelines for an LMIC. *Pediatrics*. 2023 Apr 1;151(4):e2022060679.

30. Taylor JA, Stout JW, de Greef L, et al. Use of a smartphone app to assess neonatal jaundice. *Pediatrics*. 2017 Sep;140(3). pii: e20170312.

31. US Preventive Services Task Force. Screening of infants for hyperbilirubinemia to prevent chronic bilirubin encephalopathy. *Pediatrics*. 2009;124:1172-1177.

AUTHOR AND COPYRIGHT

Author:	Barton D. Schmitt, MD, FAAP
Copyright:	1994-2026, Schmitt Pediatric Guidelines LLC. All rights reserved.
Company:	Schmitt-Thompson Clinical Content
Content Set:	Office Hours Telehealth Triage Protocols Pediatric
Version Year:	2026
Last Revised:	5/7/2026
Last Reviewed:	6/8/2026