

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-ile 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:

- Infants < 2.0 kg will be managed initially in the transitional nursery for monitoring and further recommendations.
- 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.
- SGA infants will remain on vital signs q 4 hours throughout the first 72 hours of admission.

Discharge Criteria:

- All SGA infants in the newborn nursery will demonstrate the following prior to discharge:
 - Temperature stability
 - Stable blood glucose levels
 - Adequate feeding
- 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
- 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

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

Jaundice: Adhere to “[Hyperbilirubinemia Clinical Practice Guideline](#)” for screening of jaundiced patients utilizing Bhutani nomograms.

Sepsis/Respiratory Risks

- Screen for infection per “[GBS and Suspected Sepsis Clinical Practice Guideline](#)”
- Monitor cardio-respiratory status until stable for 48 hours if \leq 35 6/7 weeks gestation

Other Labs/Imaging for evaluation and management of SGA infants depends on history and PE findings and may include:

- Ongoing blood glucose monitoring beyond protocol if poor feeding or temperature instability noted
- CBC for risk of polycythemia
- CBC, CRP for risk of sepsis
- Viral cultures (TORCH)
- Head US or head CT/ MRI
- Karyotype/DNA analysis

Feeding Difficulties/Hypoglycemia

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

For breast-feeding babies:

- Offer breast whenever infant cues to feed
- Lactation consult to see mother within 24 hrs
- Instruct mother to initiate pumping within 4 - 6 hours of delivery

For bottle-feeding babies:

Offer bottle whenever infant cues to feed

REFERENCES

Rosenberg (2008). The IUGR Newborn. *Seminars in Perinatology*, 32, 219-224.
Blackburn, RN. The IUGR Infant: Assessment, management and outcomes, AWHONN presentation, 6/29/2009.

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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