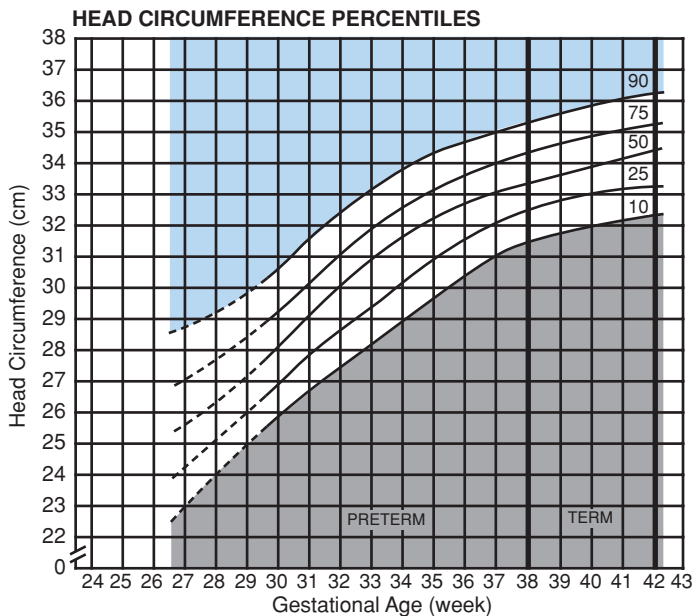
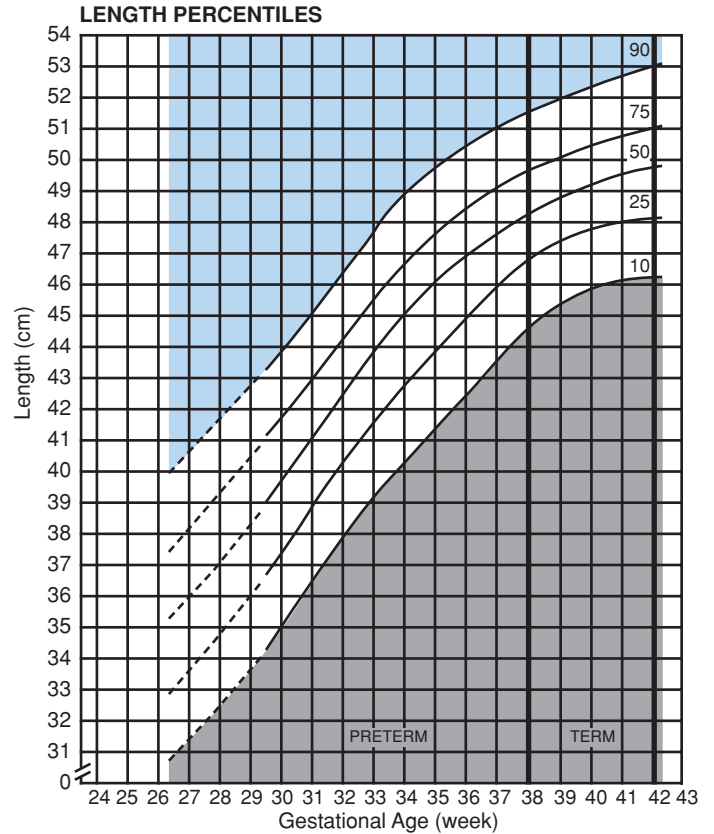
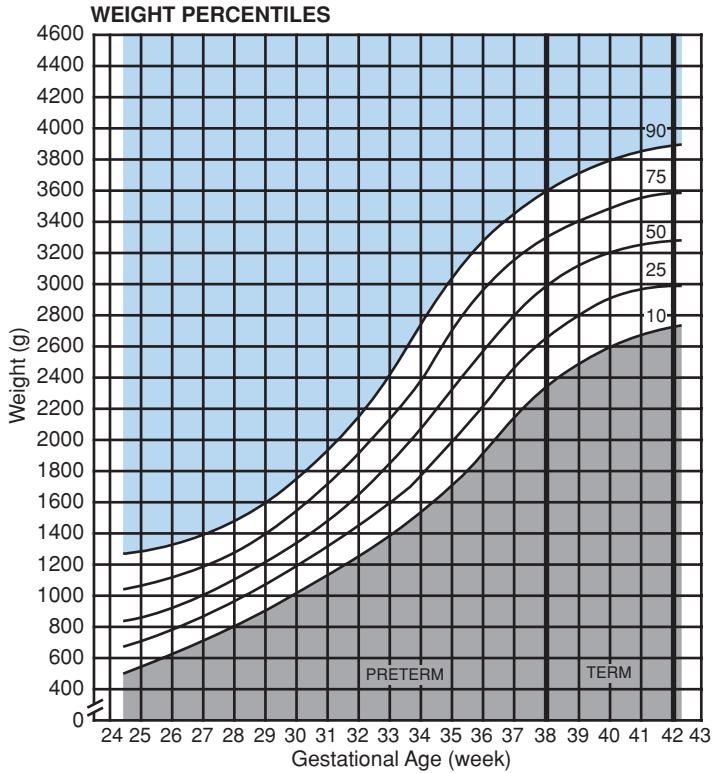


# CLASSIFICATION OF NEWBORNS (BOTH SEXES) BY INTRAUTERINE GROWTH AND GESTATIONAL AGE<sup>1,2</sup>

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ LENGTH \_\_\_\_\_  
 HOSPITAL NO. \_\_\_\_\_ SEX \_\_\_\_\_ HEAD CIRC. \_\_\_\_\_  
 RACE \_\_\_\_\_ BIRTH WEIGHT \_\_\_\_\_ GESTATIONAL AGE \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_



#### CLASSIFICATION OF INFANT\*

	Weight	Length	Head Circ.
Large for Gestational Age (LGA) (>90th percentile)			
Appropriate for Gestational Age (AGA) (10th to 90th percentile)			
Small for Gestational Age (SGA) (<10th percentile)			

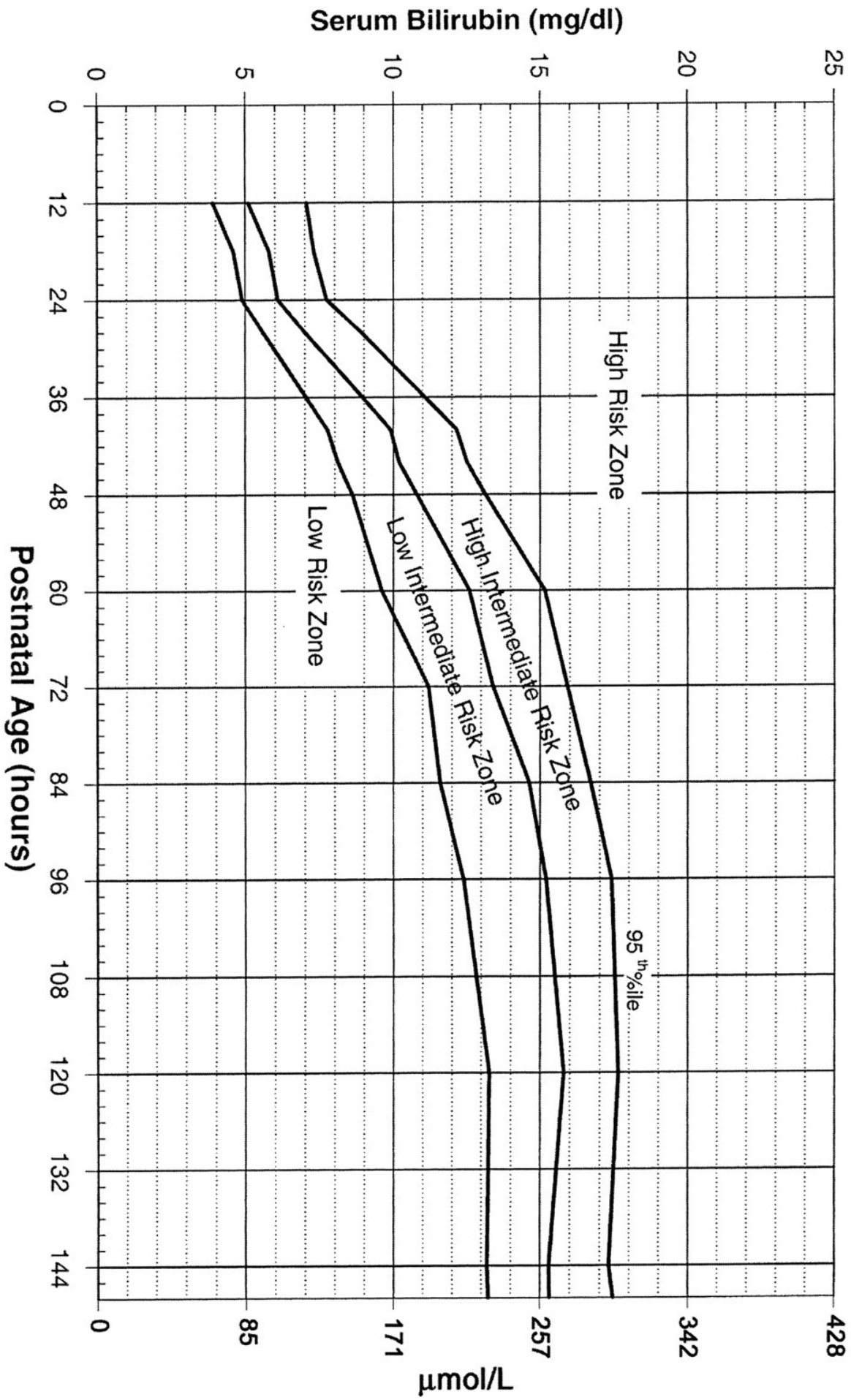
\*Place an "X" in the appropriate box (LGA), AGA or SGA) for weight, for length and for head circumference.

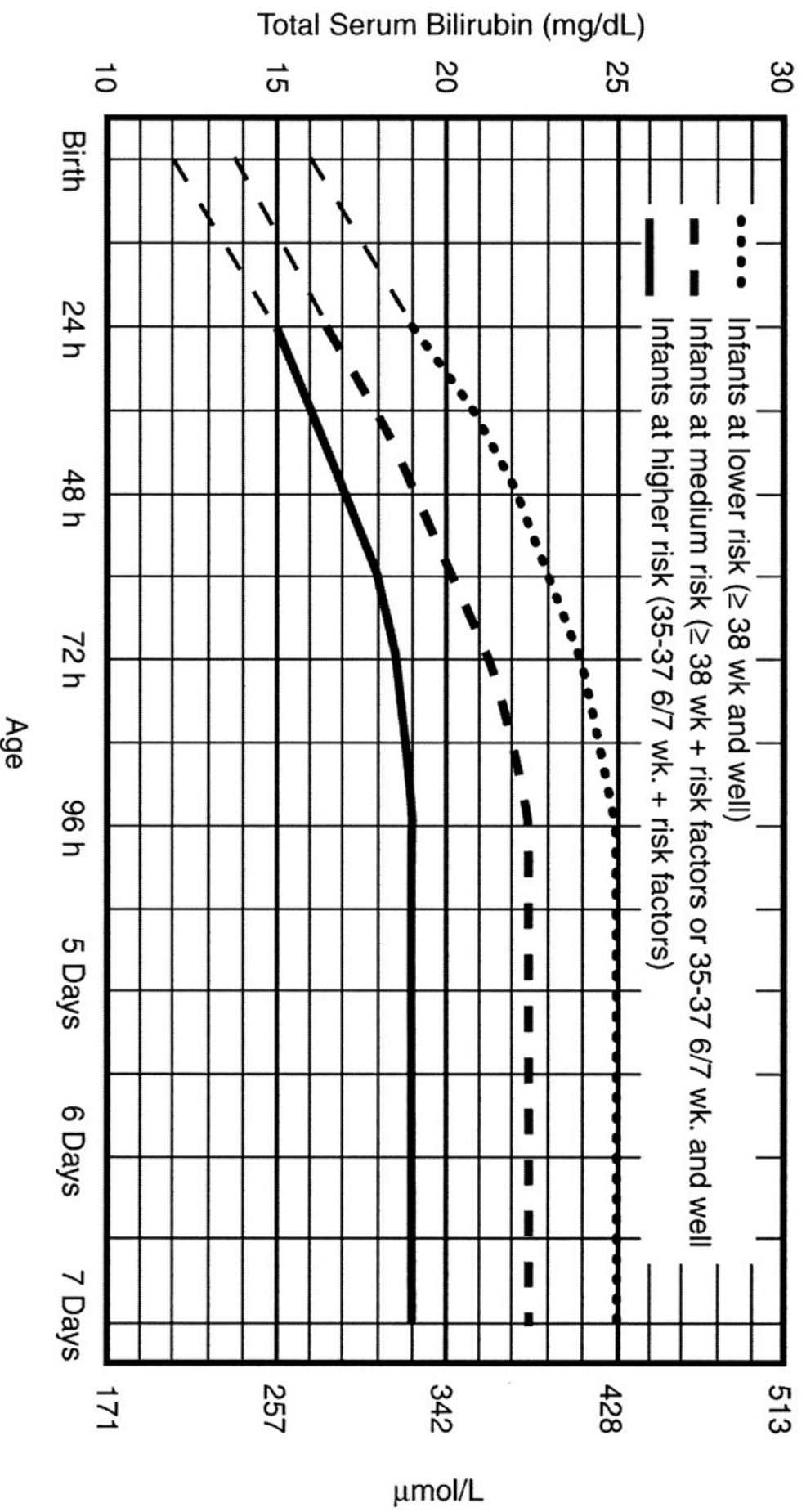
#### References

- Battaglia FC, Lubchenco LO: A practical classification of newborn infants by weight and gestational age. *J Pediatr* 1967; 71:159-163.
- Lubchenco LO, Hansman C, Boyd E: Intrauterine growth in length and head circumference as estimated from live births at gestational ages from 26 to 42 weeks. *Pediatrics* 1966; 37:403-408.

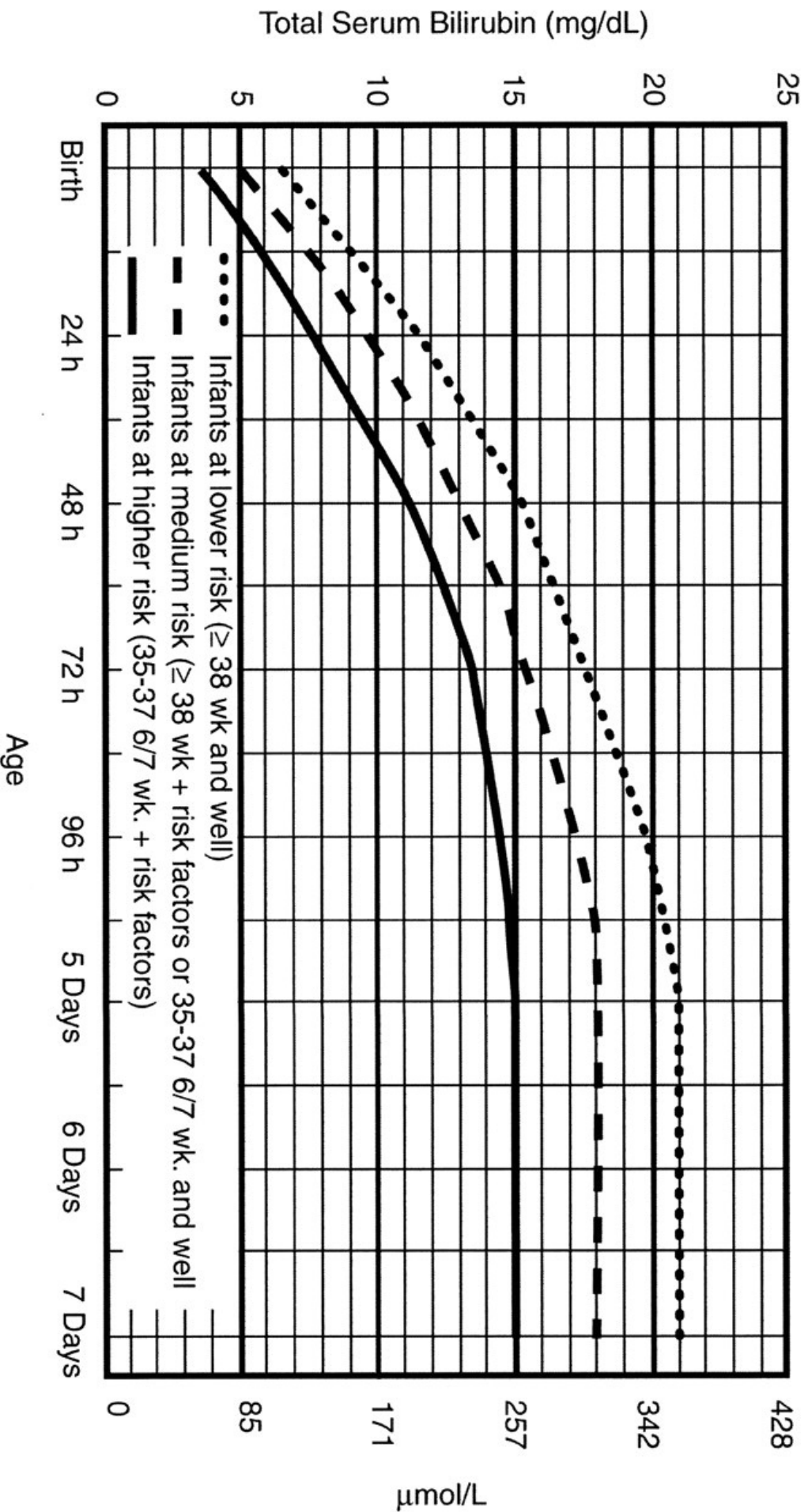
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	<b>Thể 1</b>	<b>Thể 2</b>	<b>Thể 3</b>
Ý thức	Phải xem xét	Thần thờ kém linh hoạt	Hôn mê
Tư thế	Co cứng chân và cẳng tay	Co cứng chân và cẳng tay mạnh	Tùng cơn mất não
Trương lực cơ	Bình thường	Giảm trương lực cơ	Co cứng
Phản xạ gân - xương	Tăng	Tăng	Giảm hoặc không có
Co giật cơ	Có	Có	Không
<b>Phản xạ nguyên thủy tủy sống</b>			
Mút	Có	Yếu	Biến mất
Moro	Tăng	Không hoàn toàn	Biến mất
Nắm	Bình thường - hơi tăng	Tăng	Biến mất
<b>Hệ thần kinh tự động</b>			
Đồng tử	Dãn	Co	Thay đổi hoặc nhìn sững
Hô hấp	Đều	Thay đổi về tần số và biên độ	Ngừng thở, thờ không đều
Nhịp tim	Bình thường hoặc nhanh	Nhịp tim chậm	Nhịp tim chậm
Co giật	Không	Thường có	Hiếm
EEG	Bình thường	Bệnh lý	Đẳng điện
Thời gian	< 24 giờ	2 -14 ngày	





- The dashed lines for the first 24 hours indicate uncertainty due to a wide range of clinical circumstances and a range of responses to phototherapy.
- Immediate exchange transfusion is recommended if infant shows signs of acute bilirubin encephalopathy (hypertonia, arching, retrocollis, opisthotonos, fever, high pitched cry) or if TSB is  $\geq 5$  mg/dL ( $85 \mu\text{mol/L}$ ) above these lines.
- Risk factors - isoimmune hemolytic disease, G6PD deficiency, asphyxia, significant lethargy, temperature instability, sepsis, acidosis.
- Measure serum albumin and calculate B/A ratio (See legend)
- Use total bilirubin. Do not subtract direct reacting or conjugated bilirubin
- If infant is well and 35-37 6/7 wk (median risk) can individualize TSB levels for exchange based on actual gestational age.



- Use total bilirubin. Do not subtract direct reacting or conjugated bilirubin.
- Risk factors = isoimmune hemolytic disease, G6PD deficiency, asphyxia, significant lethargy, temperature instability, sepsis, acidosis, or albumin < 3.0g/dL (if measured)
- For well infants 35-37 6/7 wk can adjust TSB levels for intervention around the medium risk line. It is an option to intervene at lower TSB levels for infants closer to 35 wks and at higher TSB levels for those closer to 37 6/7 wk.
- It is an option to provide conventional phototherapy in hospital or at home at TSB levels 2-3 mg/dL (35-50mmol/L) below those shown but home phototherapy should not be used in any infant with risk factors.