

Your Newborn's Appearance

Although the skin of a baby is soft and supple, it is not necessarily blemish-free. Babies often have rashes and blemishes which, in most cases, will go away without treatment.

Skin

The full-term newborn will be covered in vernix, a sticky white substance that provides a natural moisture barrier. After his bath, he will look more pink. Some babies may have dry skin with superficial peeling or cracks, especially if they are born past 42 weeks.

Newborn Acne

Babies often develop a harmless case of acne on their forehead, chin and cheeks. This common skin condition is called acne neonatorum. It is believed to be due to stimulation of the sebaceous glands by maternal hormones and usually resolves by the baby's fourth month without scarring. Treatment is not needed unless the rash is severe or shows no sign of getting better.

Milia

Milia or milk spots are tiny white lumps found on the face. They are caused by the retention of old skin cells and oily substances within the hair follicles. Leave them alone. They should clear up within your baby's first month of life.

Heat Rash

Some babies are prone to getting heat rash or prickly heat during hot weather. The rash usually starts around the neck. If it is bad, it can spread down to the chest and back and up around the ears and face.

Most forms of heat rash do not require any treatment. Just wipe the skin with cool water and pat dry. You can also dust the affected areas with baby powder that contains corn flour as this will help absorb excess moisture. Prevent your baby from getting heat rash by dressing him lightly and keeping him cool.



Erythema Toxicum

This is a rash that appears as small pus-filled spots on the baby's trunk and limbs, usually during the first few days after birth. If your baby is otherwise well and not bothered by the rash, leave it alone and it will disappear by the first month of life. But if your baby is unwell with symptoms such as fever and irritability and is not feeding well, take him to the doctor as the rash may be due to a bacterial, viral or fungal infection that will require prompt treatment.

Scalp

There is likely to be some swelling in the scalp due to the prolonged labour and the squeeze through the birth canal, but this will resolve within a few days.

You may also notice a soft swelling usually located on one side of your baby's scalp. This is due to a collection of blood over the skull bone layer following prolonged labour or assisted vacuum or forceps delivery. This is known as cephalhaematoma. There is no need to massage this swelling to try and reduce it. Depending on its size, it will resolve on its own after a few weeks. It does not affect your baby's head or brain growth but he may become a little jaundiced when the blood is broken down and reabsorbed into his body.

Cradle Cap

Cradle cap refers to the condition where the baby's scalp is covered with yellow greasy scales. The lesions can also affect the face, neck and ears. The condition tends to be self-limiting and resolves spontaneously within a few weeks or months. Most of the time, no treatment is required. If desired, the scales can be softened with olive oil and then removed with a soft brush prior to washing the scalp. Special shampoos are also available for treating persistent or severe cradle cap.

Epstein Pearls

Epstein pearls are tiny white or yellow lumps that appear along the gums or hard palate inside the baby's mouth. They will disappear of their own accord after about a month.

THE LATE PRETERM BABY

About 7 percent of babies in Singapore are born prematurely. The majority of them are born three to five weeks before their due date. These babies are referred to as “late preterm” babies.

Although late preterm babies may be similar in size and weight as full-term babies, they are considered “at risk” because they are physiologically and metabolically less mature. They will need to be closely monitored in hospital for at least 48 hours after birth.

Depending on the baby’s condition, the neonatologist will decide whether he needs to be observed in the normal nursery, special care nursery or neonatal intensive care unit. Many neonatology departments have standard guidelines for admitting babies born between 34 and 35 weeks into the special care nursery.

Breathing and Feeding Difficulties

Some late preterm babies may have breathing difficulties soon after birth and require oxygen or breathing assistance. This could be due to insufficient lung maturity or delay in normal lung fluid re-absorption.

As the baby may also have feeding difficulties, his blood sugars will be monitored regularly for the first day of life, especially if he has a low birth weight and needs intravenous fluid infusions. He may also need additional warmth to maintain normal body temperature in the first few days.

Discharge from Hospital

A late preterm baby will be allowed to be discharged from hospital when his vital signs are stable—normal breathing and heart rate with normal body temperature in an open cot.

The baby will undergo the routine newborn screenings and be vaccinated before he leaves the hospital. Parents will be given specific instructions for his care upon discharge. It is likely that he will have an early follow-up appointment in the hospital within one to three days to make sure that all is well.

Nutrition

The goal of optimal nutrition for premature babies is to mimic the supply of nutrition in the womb. The preferred source of nutrition is breast milk as it is well tolerated and delivers many important nutritive factors that help support the immunity of the little infant. Due to the rapid growth that needs to take place to achieve the growth he would otherwise have undergone in the womb, breast milk needs to be fortified with specialised add-on nutritive powder called human milk fortifier.

Preterm infants achieve better length, weight, head circumference measures as well as improved bone density with optimised nutrition support of a human milk fortifier than those fed breast milk alone. If breast milk is unavailable, special formulas are needed to achieve optimal nutrition for preterm infants.

Working closely with the health care team in the hospital, a mother can deliver breast milk to nourish her little one. After discharge, parents will be given special instructions to continue to fortify breast milk or provide a specialised post-discharge formula if breast milk is unavailable. This is so that the baby can catch up on the rate of growth of infants of the same gestational age who are born at term. Regular follow-up consultations with the care team during the first year of life is important to support optimal nutrition and achieve good physical and mental development outcomes in the long term for the preterm infant.

G6PD

G6PD deficiency is an inherited condition in which the body does not have enough of the enzyme glucose-6-phosphate dehydrogenase (G6PD), which helps red blood cells function normally.

It is passed down from mothers who are carriers of this condition. Their male babies have a 50 percent chance of being G6PD deficient or normal while their female babies have a 50 percent chance of being a G6PD deficient carrier or normal. It is a lifelong condition and children affected will have to observe their intake of food and medication to conserve what little G6PD they have in their bodies.

About 5 percent of Singaporean Chinese males and 3 percent of Singaporean Malay males are G6PD deficient. It is rare in the Indian ethnic group but found also in babies of Thai, Filipino and Burmese descent.

Babies with G6PD

In the baby who is G6PD deficient, the red cell membrane is more likely to break down and produce higher levels of jaundice, which can lead to brain damage. Therefore, babies who are G6PD deficient are monitored in the hospital nursery for at least 72 hours of life. The parents are counselled about the condition and informed about the need to avoid drugs and certain food that trigger red cell breakdown and how to monitor jaundice.

Parents will be provided with a list of drugs and food that babies with G6PD deficiency must avoid. This includes contact with mothballs, consumption of fava beans, sulpha drugs, antimalarials and some herbal preparations. Mothers who are breastfeeding their G6PD deficient baby will also need to avoid intake of these specific food and drugs.

Most people with G6PD deficiency do not have any symptoms while some may develop symptoms of anaemia when they are exposed to triggers such as certain food/or and drugs. Some children may require a transfusion. Only in rare cases will G6PD deficiency lead to chronic anaemia. With the right precautions, a child with G6PD deficiency can lead a healthy and active life.



JAUNDICE IN BABIES

The liver processes bilirubin in the blood and changes it into a harmless form that is passed out of the body in faeces and urine. In newborns, the liver is immature and cannot break down the bilirubin fast enough, resulting in jaundice.

Jaundice causes the baby's skin and the white part of the eyes to appear yellow. In newborns, this yellow colour starts to appear first on the face, then chest and tummy and lastly on the legs and hands as the level of bilirubin rises.

Jaundice occurs naturally in all newborns. It starts on day three of the baby's life, reaches its peak level by day five and resolves by day seven or eight. In this normal pattern, the jaundice level is not high and does not need treatment. This is called "physiological" or normal jaundice. However, in the Singaporean Chinese ethnic group, up to 30 percent of babies will develop obvious jaundice and 15 to 20 percent may have to undergo phototherapy during the newborn period.

Other Causes of Jaundice

Breastfeeding jaundice is seen in breastfed babies in the first week, especially in those that are not nursing often enough. The baby is dehydrated with excessive weight loss and shows evidence of poor passage of meconium and reduced urine output. Early and frequent breastfeeding greatly helps to reduce this type of jaundice. The colostrum that the baby receives from breastfeeding in the first days after birth will help the baby eliminate bilirubin through the faeces.

If the baby's jaundice continues to rise after two weeks and his faeces is pale and urine dark, an urgent review is needed, as this could be due to liver disease or the blockage of bile ducts.

Excessive breakdown of red cells due to the incompatibility of the blood group of mother and child, premature birth or G6PD deficiency are some of the other causes of jaundice. In many of these cases, treatment with phototherapy is usually started during the hospital stay, and specific advice will be given to parents to monitor the child at home and return for a follow-up check where necessary.

Although complications are rare, severe infant jaundice or poorly treated jaundice can cause brain damage.

Treatment for Jaundice

If the baby's bilirubin level is high, phototherapy will be advised to treat the jaundice. This is when the baby is undressed and placed under a phototherapy unit using blue spectrum light. It usually takes 24 hours and requires the baby to stay in hospital.

He will be taken out intermittently for feeding and changing during this period. Additional blood tests will be done to find out the cause of jaundice. There is no other equally effective and safe way of treating jaundice. Medications and glucose water do not reduce bilirubin levels.

Breastfeeding and Jaundice

Unless jaundice levels are very high, breastfeeding can continue together with phototherapy. Check with the hospital if it can be arranged for you to be admitted so you can remain close to your newborn and continue breastfeeding.

The paediatrician may recommend additional fluid to supplement your breastfeeding. This is especially so if the doctor diagnosed inadequate breast milk as a contributing factor to your baby's jaundice. Do not fret but continue to breastfeed your baby and/or express your breast milk regularly eight to 12 times daily while adhering to the paediatrician's advice to supplement with additional fluid during phototherapy.

If you are separated from your newborn during the phototherapy re-admission, express your milk regularly to ensure continuity of your milk supply and to avoid breast engorgement. Let your paediatrician and nurses know that you intend to continue latching on for breastfeeding. Ask that your baby not be fed using a bottle to avoid him refusing the breast later on. Nurses are adept at feeding using a syringe or cup in hospital. The milk fed can be your expressed breast milk or formula milk.

After phototherapy is completed, your baby will be discharged from hospital. An appointment will be made for a bilirubin level check within the next few days.