South Australian Perinatal Practice Guideline

Subgaleal Haemorrhage

Note:
This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.
SA Health does not accept responsibility for the quality or accuracy of material on websites linked from this site and does not sponsor, approve or endorse materials on such links.
Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.
If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient’s medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.
This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate, and which enables respectful confidential discussion.

This includes:
- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Note: The words woman/women/mother/she/her have been used throughout this guideline as most pregnant and birthing people identify with their birth sex. However, for the purpose of this guideline, these terms include people who do not identify as women or mothers, including those with a non-binary identity. All clinicians should ask the pregnant person what their preferred term is and ensure this is communicated to the healthcare team.

Explanation of the Aboriginal artwork:
The Aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the Aboriginal culture. The horseshoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant woman. The smaller horseshoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

Australian Aboriginal Culture is the oldest living culture in the world, yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio-economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectfully manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

Purpose and Scope of Perinatal Practice Guideline

The purpose of this guideline is to provide clinicians with information to identify risk factors, recognise signs and symptoms, monitor and escalate care for the newborn with a subgaleal haemorrhage (SGH) to reduce the incidence of neonatal adverse outcomes.
Flowchart 1 | Management of SGH in Regional/Non-Tertiary Centres

Surveillance for SGH Post Instrumental Birth at Regional/Non-Tertiary Centres

**LEVEL 1 SURVEILLANCE**
- ALL infants born via instrumental birth or second stage LSCS without risk factors (see level 2 surveillance box)

**MANAGEMENT**
- Take umbilical cord bloods (pH/Lactate)
- Avoid hats to allow for observations
- Inspect and palpate scalp for SGH
- Give IM Vitamin K (with consent)

**OBSERVATIONS**
- Activity, colour, HR, RR, and head circumference
- Frequency: Baseline at birth, then at 1 hour and 4 hours of age
- 
  *Escalate to level 2 surveillance if concerned or level 3 surveillance if SGH suspected, at any stage.*

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**LEVEL 2 SURVEILLANCE**
- ALL infants born via instrumental birth or second stage LSCS with one or more of the following risk factors:
  - Total vacuum extraction time > 20 minutes and/or > 3 pulls and/or > 2 cup detachments
  - 5 minute Apgar score ≤ 7
  - At clinicians request after difficult instrumental birth

**MANAGEMENT**
- Take umbilical cord bloods (pH/Lactate) and consider collection of FBE (with platelet count) and blood gas
- Avoid hats to allow for observations
- Inspect and palpate scalp for SGH
- Give IM Vitamin K (with consent)
- Consider admission to appropriate clinical area for closer monitoring/surveillance on individual basis

**OBSERVATIONS**
- Activity, colour, HR, RR, head circumference and pulse oximetry
- Frequency: Baseline, then 1-hourly for the first two hours of age
- Continue 2-hourly observations until six hours of age, followed by 4-hourly observations until 12 hours of age
- Use pulse oximeter for accurate recording of heart rate and early recognition of tachycardia
- Further monitoring will depend on clinical situation and medical advice
- 
  **Escalate to level 3 surveillance if SGH suspected, at any stage.**

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**LEVEL 3 SURVEILLANCE**
- ALL infants with suspected SGH or concerns on level 2 surveillance

**>> URGENT MEDICAL REVIEW<<**

**MANAGEMENT**
- Give IM Vitamin K (with consent)
- Call MedSTAR (13 78 27) to consider retrieval to a level 5 or 6 tertiary hospital
- Transfer to neonatal unit or appropriate clinical area for high level monitoring or resuscitation
- Call local blood bank to check for availability of blood products urgently
- IV access or UVC
- Urgent investigations to include: FBE (with platelet count), blood gas with lactate, extended coagulation studies, group and crossmatch
- Newborn screening test if transfusion likely

**OBSERVATIONS**
- Continuous monitoring of HR, RR, and Oxygen saturation (document hourly)
- BP 15 minutes plus, perfusion/capillary refill, activity, colour, and urine output
- Hourly head circumference and scalp examination

Observe for signs of Hypovolaemic Shock
- Tachycardia > 160 bpm or increase of HR baseline by 20 bpm
- Capillary refill > 3 seconds or poor perfusion
- Mean BP < 40 mmHg
- PH < 7.3 OR Lactate ≥ 3 mmol/L

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Management of SGH is an EMERGENCY and may require resuscitation and correction of hypovolaemia, anaemia, coagulopathy with fluid and massive transfusion of blood products.
**Flowchart 2 | Management of SGH at Tertiary (Level 5 or 6) Hospitals**

**Surveillance of SGH Post Instrumental Birth at Tertiary (Level 5 or 6) Hospitals**

**LEVEL 1 SURVEILLANCE**
- ALL infants born via instrumental birth or second stage LSCS in the absence of risk factors (see level 2 surveillance box).

**MANAGEMENT**
- Take umbilical cord bloods (pH/Lactate).
- Avoid hats to allow for observations.
- Inspect and palpate scalp for SGH.
- Give IM Vitamin K (with consent).

**OBSERVATIONS**
- Activity, colour, HR, RR and head circumference.
- Frequency: Baseline at birth, then at 1 hour of age and 4 hours of age.

*Escalate to level 2 surveillance if concerned OR level 3 surveillance if SGH suspected, at any stage.*

**LEVEL 2 SURVEILLANCE**
- ALL infants born via instrumental birth or second stage LSCS with one or more of the following risk factors:
  - Total vacuum extraction time > 20 minutes; and/or > 3 pulls; and/or > 2 cup detachments.
  - 5 minute Apgar score ≤ 7.
  - At clinician request after difficult instrumental birth.

**MANAGEMENT**
- Take umbilical cord bloods (pH/Lactate) and consider collection of FBE (with platelet count) and blood gas.
- Avoid hats to allow for observations.
- Inspect and palpate scalp for SGH.
- Give IM Vitamin K (with consent).
- Consider admission to level 2 SCN for closer monitoring on individual basis.

**OBSERVATIONS**
- Activity, colour, HR, RR and head circumference and pulse oximetry.
- Frequency: Baseline at birth, then, 1-hourly for the first two hours of age.
- Continue 2-hourly observations until six hours of age, followed by
- 4-hourly observations until 12 hours of age.
- Use pulse oximeter for accurate recording of heart rate and early recognition of tachycardia.
- Further monitoring will depend on clinical situation and medical advice.

*Escalate to level 3 surveillance if SGH suspected, at any stage.*

**LEVEL 3 SURVEILLANCE**
- ALL infants with suspected SGH at level 2 surveillance.

**>> URGENT REGISTRAR/NNP REVIEW<<**

**MANAGEMENT**
- Give IM Vitamin K (with consent).
- Transfer to SCN unit or NICU at medical discretion.

**OBSERVATIONS**
- Continuous monitoring of HR, RR and Oxygen saturation.
- BP 15 minutes for two hours plus, perfusion/capillary refill, activity, colour and urine output.
- 1-hourly for six hours.

- Hourly head circumference and scalp examination for six hours.
- Obtain IV access or UVC.
- Urgent investigations: FBE, blood gas with lactate, extended coagulation studies, group and crossmatch and newborn screening test if transfusion likely.

**Observe for signs of Hypovolaemic Shock**
- Tachycardia > 160 bpm or increase of HR baseline by 20 bpm.
- Capillary refill > 3 seconds or poor perfusion.
- Mean BP < 40 mmHg.
- pH < 7.3 OR Lactate ≥ 3 mmol/L.

Management of SGH is an EMERGENCY and may require resuscitation and correction of hypovolaemia, anaemia, coagulopathy with fluids and massive transfusion of blood products.
Summary of Practice Recommendations

The intensity of surveillance for subgaleal haemorrhage (SGH) is determined by the intrapartum risk factors and the infant's condition after birth.1

Structured surveillance (as outlined in flowcharts 1 and 2) is required for all newborn infants born by instrumental birth during the first 24 hours of life.

Symptomatic SGH is an emergency and may be life-threatening due to haemorrhagic shock. Careful monitoring, early recognition, and appropriate management is required.

A neonatologist should be consulted immediately regarding managing potential or actual haemorrhagic shock. This may include resuscitation with replacement of the blood volume lost in the subgaleal space, correction of coagulopathy, supportive treatment, and urgent retrieval to a level 5 or 6 tertiary centre.

Neonates birthed via instrumental assistance should receive intramuscular Vitamin K prophylaxis soon after birth.
Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>&gt;</td>
<td>Greater than</td>
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<tr>
<td>≥</td>
<td>Greater than or equal to</td>
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<tr>
<td>&lt;</td>
<td>Less than</td>
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<tr>
<td>≤</td>
<td>Less than or equal to</td>
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<tr>
<td>BP</td>
<td>Blood Pressure</td>
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<tr>
<td>bmp</td>
<td>Beats per minute</td>
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<tr>
<td>cm</td>
<td>Centimeter(s)</td>
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<tr>
<td>mmol/L</td>
<td>Millimole(s) per liter</td>
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<td>mL</td>
<td>Millilitre(s)</td>
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<tr>
<td>mg</td>
<td>Milligram(s)</td>
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<tr>
<td>microg</td>
<td>Microgram(s)</td>
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<tr>
<td>NNP</td>
<td>Neonatal Nurse Practitioner</td>
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<td>FBE</td>
<td>Full blood examination</td>
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<tr>
<td>FFP</td>
<td>Fresh frozen plasma</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HC</td>
<td>Head Circumference</td>
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<tr>
<td>HR</td>
<td>Heart rate</td>
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<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>kg</td>
<td>Kilogram(s)</td>
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<tr>
<td>LSCS</td>
<td>Low segment caesarean section</td>
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<tr>
<td>mmHg</td>
<td>Millimeter(s) of mercury</td>
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<tr>
<td>MTP</td>
<td>Massive Transfusion Protocol (also encompasses critical bleeding protocol)</td>
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<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
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<tr>
<td>NICU</td>
<td>Neonatal Intensive Care Unit</td>
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<tr>
<td>pH</td>
<td>Potential of hydrogen</td>
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<tr>
<td>RBC</td>
<td>Red blood cells</td>
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<tr>
<td>RR</td>
<td>Respiratory rate</td>
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<tr>
<td>SCN</td>
<td>Special care nursery</td>
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<tr>
<td>SGH</td>
<td>Subgaleal haemorrhage</td>
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<tr>
<td>SpO2</td>
<td>Oxygen saturation</td>
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<tr>
<td>UVC</td>
<td>Umbilical venous catheter</td>
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<tr>
<td>VII</td>
<td>Seven</td>
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Introduction

A Subgaleal Haemorrhage (SGH) is a potentially lethal condition for a newborn. It is caused by rupture of the emissary veins during birth, which traverses from the scalp to the dural venous sinuses. This may result in haemorrhage into the subgaleal space between the periosteum and the epicranial aponeurosis ("galea") (see figure 1).

The subgaleal space contains loose connective tissue and covers the entire cranial vault, extending from the orbital ridges to the nape of the neck and laterally to the ears. It is not limited by sutures and may quickly expand to accommodate 250 mL of blood. The neonatal blood volume is approximately 85 mL/kg, therefore, a 3 kg neonate may lose up to 75% of their blood volume into the subgaleal space.

Moderate to severe SGH may be associated with hypovolaemic shock, anaemia, coagulopathy, and encephalopathy with significant morbidity and mortality.
The incidence of SGH is variably reported, though it is estimated to occur approximately 1 in 2000 births.\(^6\) It may happen following a normal vaginal birth, forceps assisted birth or caesarean section, however, higher incidences of SGH are noted following ventouse births (approximately 1 in 300 of ventouse births)\(^3,6\) due to the application of rotational and tractional forces on the scalp.

The majority of SGH can be detected within the first hour of birth, though the presentation may be more insidious. The average time to diagnose SGH is 1 to 6 hours after birth, so careful observations need to be always performed.\(^7\)

It is recognised that with careful monitoring, early diagnosis and prompt aggressive management, the complications of late detection may be prevented.\(^3\)

**Differential Diagnosis**

(See figure 1)

**Caput succedaneum/Chignon**
- A localised serosanguinous (fluid-like) collection in the subcutaneous scalp layer, caused by pressure on the head during labour and birth.
- It is firm, not fluctuant, has distinct borders, and is usually located at the presenting part and/or the location of ventouse cup.
- It typically reduces in size after 1 hour and resolves within approximately 18 hours.

**Cephalohaematoma**
- Caused by pressure and friction on the head during labour and birth, with rupture of diploic veins and haemorrhage between the periosteum and the skull.
- It is a fluctuant swelling confined by periosteum and does not cross suture lines.
- It may increase in size during the first 24 hours, though it rarely requires treatment.

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**Figure 1:** Location of injury in soft tissue places on the scalp and head. Extracted from Rosen et al. (2017). Operative Vaginal Delivery. In: Malvasi, A., Tinelli, A., Di Renzo, G. (eds) Management and Therapy of Late Pregnancy Complications. Springer, Cham. p. 160. https://doi.org/10.1007/978-3-319-48732-8_10
Risk Factors for SGH

- **Vacuum extraction (ventouse):**
  - prolonged extraction time (> 20 minutes) and/or > 3 pulls and/or > 2 cup detachments
  - incorrect positioning of the cup: leading-edge < 3 cm from anterior fontanelle, or unevenly applied to one parietal bone rather than evenly across the sagittal suture
  - failed vacuum extraction.

  *Note: A difficult vacuum extraction most commonly precedes SGH with the application of rotation and traction forces.*

- **Forceps delivery:**
  - high or mid-cavity birth
  - failed forceps.

- **Nulliparity**

- **Apgar score ≤ 7 at 5 minutes**

- **At clinician request following difficult instrumental birth**

Clinical Manifestations

**Local Signs of SGH**

- A diffuse, fluctuant, ballotable scalp swelling of the scalp that may shift with movement that is gravity dependent and is **NOT** limited by the sutures.
- Described as ‘an old leather pouch filled with fluid’ or ‘water-filled balloon’.
- Increasing head circumference.

  *Note: this is a late sign as large blood loss can occur with a small increase in HC.*

- Irritability and pain with handling.
- As haemorrhage extends, the ear lobes may be elevated and displaced inferiorly, and eyelids may appear swollen.

**Systemic Signs of SGH**

**Hypovolemic shock:**

- Early signs:
  - **tachycardia** is often the first sign of hypovolaemia
  - tachypnoea
  - poor perfusion (capillary refill > 3 seconds, cool peripheries)
  - decreased activity
  - pallor.

- Late signs:
  - hypotension; anaemia; acidosis; coagulopathy; neurological dysfunction including seizures
  - end organ dysfunction (e.g., liver and kidney dysfunction).

Management

The level of surveillance a neonate requires post instrumental birth will be dependent on the clinical picture and observed risk factors. At a minimum **ALL** neonates born via instrumental birth or second stage LSCS, will be require **level 1 surveillance.**

Any concerns at level 1 surveillance or noted risk factors for SGH during or after instrumental birth require **level 2 surveillance.**

**Level 3 surveillance** pathway should be followed, if SGH is suspected or concerns at level 2 surveillance.
Note: Management of SGH is a MEDICAL EMERGENCY and may require resuscitation and correction of hypovolaemia, anaemia, coagulopathy with fluids and massive transfusion of blood products.

Level 1 Surveillance (All LHNs)

Indication:
- minimum surveillance for ALL infants born via instrumental birth OR second stage LSCS WITHOUT risk factors (see Risk factors for SGH on this document).

Management:
- collect umbilical cord bloods (pH/lactate)
- avoid hats to allow observations
- inspect and palpate scalp for diffuse fluctuant swelling or signs of SGH
  - document the location and size of the swelling
- give IM Vitamin K (with consent)
  - If Vitamin K is declined, medical staff must counsel parents about the risks.
- perform baseline observations immediately after birth including:
  - activity, colour, heat rate (HR), respiration rate (RR) and head circumference
  - repeat observations at 1 hour and 4 hours of age.

Note: If there are concerns with level 1 surveillance, escalate to level 2 surveillance OR level 3 surveillance if SGH is suspected at any stage.

Level 2 Surveillance (All LHNs)

Indication:
- minimum observations recommended for ALL infants born via instrumental vaginal birth or second stage LSCS WITH one or more risk factors (see Risk factors for SGH on this document) OR
- clinical concerns with level 1 surveillance or any uncertainty (e.g., diffuse boggy head swelling).

Note: Escalate to level 3 surveillance is SGH suspected at any stage of care.

Management:
- collect umbilical cord bloods (pH, lactate)
- consider collection of FBE (with platelet count) and blood gas
- avoid hats to allow observations
- inspect and palpate scalp for diffuse fluctuant swelling
  - document the location and size of the swelling
- give IM Vitamin K (with consent)
  - If Vitamin K is declined, medical staff must counsel parents about the risks
- consider admission to level 2 SCN or appropriate clinical area for closer monitoring/surveillance on individual basis
- perform baseline observations immediately after birth (activity, colour, HR, RR, head circumference and pulse oximetry)
  - use pulse oximeter for accurate recording of heart rate and early recognition of tachycardia
- repeat observations 1-hourly for the first two hours of age, then 2-hourly until six hours of age, followed by 4-hourly observations until 12 hours of age
- further monitoring will depend on clinical situation and medical advice.

Level 3 Surveillance (All LHNs)

Indication:
- ALL infants with suspected SGH or concerns on level 2 surveillance.
Management:

- **URGENT MEDICAL REVIEW**
- see specific management for Regional/Non-Tertiary Centres OR Tertiary (Level 5 or 6) Hospital guidelines below if SGH is confirmed or highly suspected.

### Level 3 Surveillance Management for Regional/Non-Tertiary Centres

- **URGENT MEDICAL REVIEW**
- Give IM Vitamin K (with consent)
- Call MedSTAR (13 78 27) to consider retrieval to a level 5 or 6 tertiary hospital
- Transfer to neonatal unit or other appropriate clinical area for high level monitoring or resuscitation
- Contact local blood bank to check for availability of blood products urgently
- Obtain IV access or UVC
- Collect and send urgent investigations for:
  - full blood examination (with platelet count)
  - blood gas (including lactate)
  - group and crossmatch
  - extended coagulation studies
  - newborn screening test if transfusion likely.
- Continuous monitoring of observations with hourly documentation of (HR, RR and Oxygen saturation)
- Monitor BP 15 minutely, AND:
  - capillary refill time and peripheral perfusion
  - activity and colour
  - urine output.
- Hourly scalp examination (observation and palpation) and head circumference
- Confirm Vitamin K has been given (with consent)
- Monitor for signs of hypovolaemic shock. If signs present Call MedSTAR (13 78 27) urgently for further management.

#### Signs of hypovolaemic shock:

- tachycardia > 160 bpm or > 20 bpm above baseline
- poor peripheral perfusion or capillary refill > 3 seconds
- mean blood pressure < 40 mmHg in term infant
- pH < 7.3 or lactate ≥ 3 mmol/L.

**If signs of hypovolaemic shock present, consider:**

- 10–20 mL/kg of 0.9% sodium chloride or 15 mL/kg of crossed matched or O negative blood
- further blood products/paediatric/neonatal Massive Transfusion Protocol (MTP) as per local guidelines in discussion with Neonatologist via MedSTAR which may include RBC, Platelets, FFP, Cryoprecipitate, Calcium and Tranexamic acid
- acidosis correction with sodium bicarbonate:
  - For half correction (mL) = Base Deficit x Weight (Kg) x 0.3
- respiratory support: including intubation and ventilation
- umbilical lines
- inotropes, though volume expansion is mainstay of treatment
- repeat investigations every 4 hours (blood gas, FBE and coagulation profile)
- head turban has no proven benefit.

### Level 3 Surveillance Management for Tertiary (Level 5 or 6) Hospitals

- **Urgent Registrar/Neonatal Nurse Practitioner (NNP) review**
- Give IM Vitamin K (with consent)
- Transfer to SCN, or NICU at medical discretion
Continuous monitoring with hourly documentation of: HR, RR and oxygen saturation

Monitor BP 15 minutely for the first two hours, then 1-hourly for six hours and note:
- capillary refill time and peripheral perfusion
- activity and colour
- urine output.

Hourly scalp examination (observation and palpation) and head circumference for the first six of birth

Obtain IV access or UVC

Collect and send urgent investigations for:
- full blood examination
- blood group and crossmatch
- extended coagulation studies
- newborn screening test if transfusion likely.

Monitor for signs of Hypovolaemic shock

**Signs of hypovolaemic shock:**
- tachycardia > 160 bpm or HR > 20 bpm above baseline
- poor peripheral perfusion or capillary refill > 3 sec
- mean blood pressure < 40 mmHg in term infant
- pH < 7.3 or lactate ≥ 3 mmol/L.

**Management of hypovolaemic shock**

- **Urgent Resuscitation of Circulatory Volume and Correction of Coagulopathy with consideration of:**
  - 10–20 mL/kg of 0.9% sodium chloride, or 15 mL/kg urgent crossmatched or O negative blood
  - Repeat 10 mL/kg bolus as clinically indicated

  *Note: If > 40 mL/kg packed red blood cells (RBC) required, consult with Haematology and consider paediatric/ neonatal Massive Transfusion Protocol (MTP) as per local guidelines.*

- Monitor ionised Calcium
- If coagulation profile abnormal, consider 10–15 mL/kg of fresh frozen plasma (FFP)
- If continued bleeding or fibrinogen level < 1.5 g/L, consider Cryoprecipitate 5 mL/kg
- If Platelet count < 50 x 10^9 /L, consider 10–15 mL/kg Platelets
- Discuss with Haematologist about the need for recombinant factor VIIa and/or Tranexamic acid
- Consider elective intubation and ventilation for worsening shock
- Consider inotropic support and functional cardiac ultrasound
- Consider acidosis correction with sodium bicarbonate:
  - **Half correction (mL) = Base Deficit x Weight (Kg) x 0.3**

- Strict fluid balance
- Obtain blood product administration consent

**Review for Concomitant Injuries**

- Neonatal Encephalopathy occurs in 62–72% of infants with SGH.
- Intracranial haemorrhage and cerebral oedema occurs in 33–40% of cases.
- Less common or rare: skull fracture, dural tear with herniation, superior sagittal sinus rupture, pseudomeningocele and encephalocele, subconjunctival or retinal haemorrhage.

**Further Investigations**

- Repeat FBE and coagulations studies as required, then 4-6 hourly until stable.
- Consider cranial imaging (e.g., Ultrasound or MRI).
Documentation

SGH diagnosis must be recorded accurately under Complication Neonate in the Labour and Birth (Mother) section in the electronic medical record (EMR).

For health networks that do not have access to EMR, SGH findings must be recorded in neonatal and maternal medical records and in the Supplementary Birth Record, in the Baby Details section under Condition Occurring During Birth as other (specify): subgaleal haemorrhage.

Communication with Parents

- Keep parents informed with open and honest communication.
- Obtain consent for the administration of blood products.

Aboriginal woman and/or families should be consulted on the care of the newborn baby in the first instance. Consult with an Aboriginal healthcare worker to ensure cultural sensitivities and support is available if requested. Aboriginal women may experience feelings of loneliness and disconnectedness from family and country and may need to talk to an Aboriginal Health Professional (if the family is transferred in via MedStar).

Discharge Criteria and Follow up

- With symptomatic SGH, consider transfer to postnatal ward if stable for 24 hours monitoring with ongoing prior to discharge.
- A newborn who is asymptomatic, but with suspected SGH should be kept monitored closely for 12–24 hours. If stable following this period of observation, the newborn could be transferred to Postnatal Ward for further observation until discharge.
- Following discharge, newborn should be reviewed by General Practitioner (GP) within 1–2 weeks. Ensure that the mother and baby have appropriate paperwork/discharge summary to present to their GP.
- Other follow up plans as per multidisciplinary plan: Maternity outreach, Aboriginal community-controlled health services, Neonatal outreach and Child and Family Health Service, or Department for Child Protection, as relevant.
- Maternity outreach or community outreach to inspect infants head with head circumference measurement and signs of jaundice during their follow up. Should there be any concerns, to discuss with local Paediatrician/ medical officer.
References


Resources

- SAPPGs Web-based App
  Practice Guidelines (sahealth.sa.gov.au)
- Medicines Information
  Medicines Information Homepage - SA Pharmacy Medicines Information Service - LibGuides at South Australian Health Library Service (sahealthlibrary.sa.gov.au)
- SA Health Pregnancy
  Pregnancy | SA Health
- Australian Government Pregnancy, Birth and Baby
  Pregnancy, Birth and Baby | Pregnancy Birth and Baby (pregnancybirthbaby.org.au)
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Write Group Leads
Dr Kristina Sibbin
Dr Michael Hewson
Dr Amy Keir
Dr Alvin Tan

Write Group Members
Dr Gillian Watterson
Ella Wedd

Other Major Contributors
Marnie Aldred
Dr Elizabeth Beare
Elizabeth Bennett
Jo French
Meredith Hobbs

SAPPG Management Group Members
Dr Michael McEvoy (Chair)
Monica Diaz (SAPPG EO)
Marnie Aldred
Dr Elizabeth Allen
Elise Bell
Elizabeth Bennett
Corey Borg
John Coomblas
Dr Danielle Crosby
Tania Day
Kate Greenlees
Dr Linda McKendrick
Dr Scott Morris
Dr Anupam Parange
Dr Shruti Tiwari
Dr Charlotte Taylor
Allison Waldron