



<b>CLINICAL GUIDELINE</b>	
<b>Pulmonary Haemorrhage</b>	
<b>Scope (Staff):</b>	Nursing and Medical Staff
<b>Scope (Area):</b>	NICU KEMH, NICU PCH, NETS WA

This document should be read in conjunction with this [DISCLAIMER](#)

### Key Points

- A form of fulminant lung oedema.
- Usually complicates other significant disease process e.g. HMD, Meconium aspiration, asphyxia, sepsis, patent ductus arteriosus.
- Rarely as part of bleeding diathesis.

### Risk Factors

- Prematurity / Lower birth weight.
- Overwhelming sepsis.
- Hypoxia.
- Left-right shunts causing pulmonary flooding.
- Surfactant administration.
- Severe RDS.

### INVESTIGATIONS

- Check Hb, coagulation screen.
- Check ABG, biochemistry.
- CXR: often shows a white-out.
- Look for sepsis.


### Management:

- May require ventilation.
- Use higher PEEP (6-7cmH<sub>2</sub>O).
- Maintain normal SPO<sub>2</sub>.
- Consider surfactant administration: **discuss with the on-call neonatologist.**
- Volume expansion may be indicated. **Avoid over-vigorous fluid administration, which can worsen the condition.**
- In cases where volume overload (e.g. large PDA in preterm infant) is thought to be contributing to pulmonary haemorrhage, consider dose of Frusemide at 1mg/kg.
- Ensure Vitamin K given.

- Avoid unnecessary ETT suctioning.

**ALWAYS CONSIDER TAKING NITRIC OXIDE ON RETRIEVAL**

This document can be made available in alternative formats on request for a person with a disability.

File Path:			
Document Owner:	Neonatology		
Reviewer / Team:	Neonatal Coordinating Group		
Date First Issued:	August 2009	Last Reviewed:	1 <sup>st</sup> July 2017
Amendment Dates:		Next Review Date:	1 <sup>st</sup> July 2020
Approved by:	Neonatal Coordinating Group	Date:	26 <sup>th</sup> September 2017
Endorsed by:	Neonatal Coordinating Group	Date:	
Standards Applicable:	NSQHS Standards: 		
<b>Printed or personally saved electronic copies of this document are considered uncontrolled</b>			