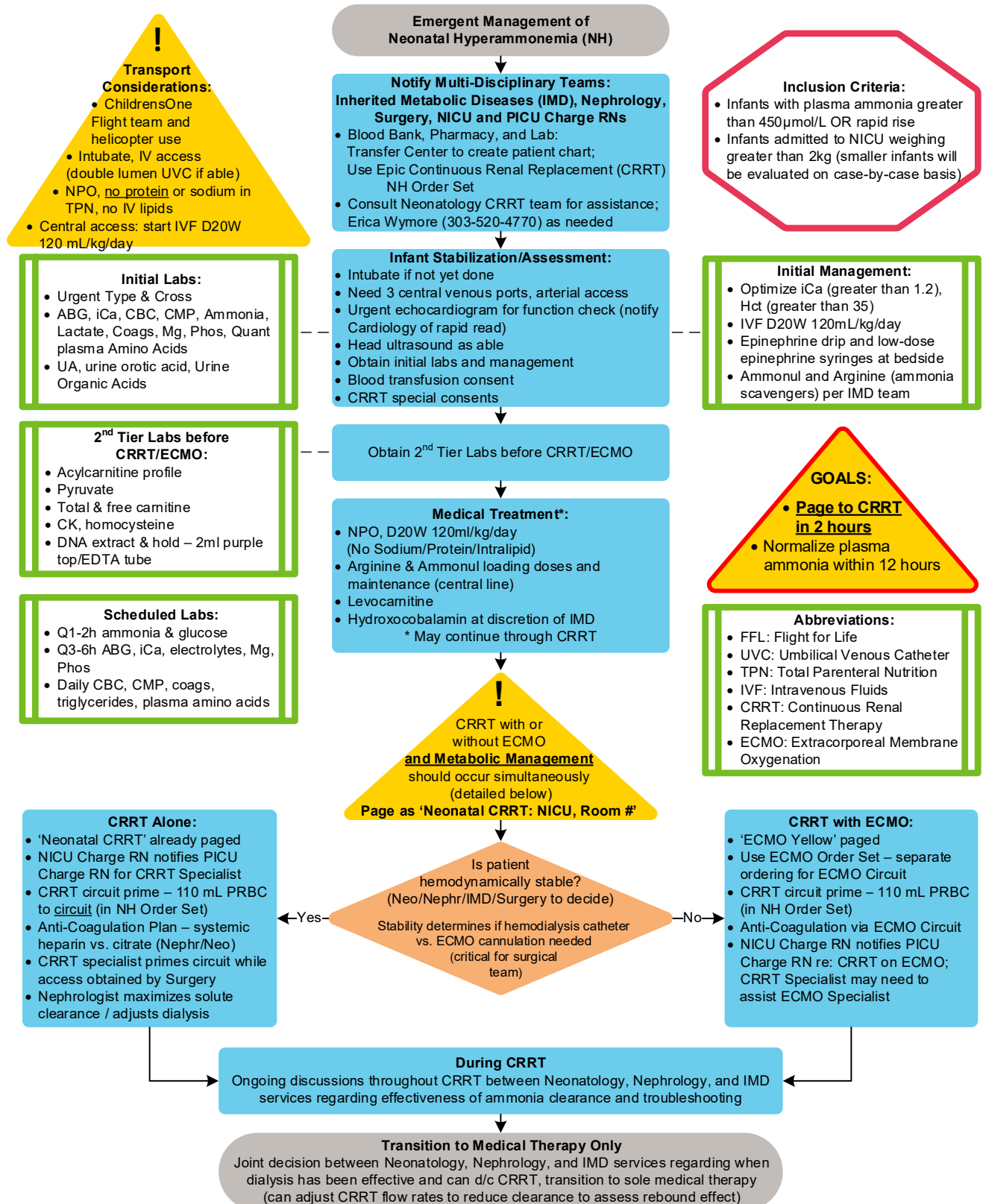


# NICU: NEONATAL HYPERAMMONEMIA

## Emergent Management of Acute Neonatal Hyperammonemia (NH)

### ALGORITHM



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## TARGET POPULATION

### Inclusion Criteria

- Infants with plasma ammonia level **greater than** 450 $\mu$ mol/L **OR** rapid rate of rise
- Infants admitted to NICU, weighing greater than 2kg (smaller infants determined on case by case basis)

## BACKGROUND | DEFINITIONS

### Background

This multidisciplinary clinical pathway has been developed in an effort to improve neurologic outcomes in the rare presentation of neonatal hyperammonemia (NH) due to inborn errors of metabolism such as urea cycle defects (UCD), organic acidemias (OA) and fatty acid oxidation disorders (FAOD). The duration and level of the hyperammonemic state determine the extent of neurologic injury and degree of long-term neurodisability - a true **Metabolic Emergency**.

### Objectives

- Prioritize and coordinate efforts by a multidisciplinary team including Nephrology, Surgery, Inherited Metabolic Diseases (IMD) and Neonatology caring for infants in the NICU to:
  - Obtain rapid central vascular access
  - Initiate Continuous Renal Replacement Therapy (CRRT) for ammonia removal
  - Initiate metabolic therapy for ammonia scavengers
- Interventions to occur concomitantly
- Decision to CRRT in 2 hours, with hospital-wide response to page '**Neonatal CRRT: NICU, Room Number**' similar to ECMO Yellow
- Once on CRRT, normalize plasma ammonia (to less than 100  $\mu$ mol/L) within 12 hours

### Abbreviations

- ABG: Arterial Blood Gases
- CBC: Complete Blood Count
- CK: Creatine Kinase
- CMP: Comprehensive Metabolic Panel

- CRRT: Continuous Renal Replacement Therapy
- DNA: Deoxyribonucleic Acid
- Echo: Echocardiogram
- ECMO: Extracorporeal Membrane Oxygenation
- EDTA: Ethylenediaminetetraacetic acid
- Epi: Epinephrine
- FAOD: Fatty Acid Oxidation Disorders
- HCT: Hematocrit
- HUS: Head Ultrasound
- iCa: Ionized Calcium
- IMD: Inherited Metabolic Diseases
- IVF: Intravenous Fluids
- Mg: Magnesium
- NH: Neonatal Hyperammonemia
- NPO: Nothing by Mouth
- OA: Organic Acidemias
- Phos: phosphorus
- PRBC: Packed Red Blood Cell
- TPN: Total Parental Nutrition
- UA: Urinalysis
- UCD: Urea Cycle Defects
- UVC: Umbilical Venous Catheter

## INITIAL EVALUATION

### Neonatology Considerations for Transport

- a. Helicopter use if able - emergent transport
- b. Intubation if not done already (Children's One Flight team or referring provider)
- c. Obtain IV access - prefer UVC double lumen but should not delay transport
- d. NPO, no parenteral nutrition (PN), remove all protein intake, no IV lipids
- e. If UVC access – dextrose 20% (D20W) at 120ml/kg/day; if PIV- dextrose 12.5% (D12.5W) at 180 ml/kg/day (GIR 16 mg/kg/min)
- f. Obtain electrolytes prior to transport (if not done already/recently)

### Neonatology Pre- CRRT Clinical Considerations

- a. Notification of multi-disciplinary team regarding pending patient: IMD, Nephrology, Surgery; NICU Charge RN to notify PICU Charge RN of infant admission and presumptive diagnosis
- b. Urgent central venous (3 ports) and arterial access - for metabolic medications, monitoring
- c. Prioritize correction of hypocalcemia/anemia: iCa greater than 1.2 mmol/L, Hct goal greater than 35%
- d. Urgent echocardiogram to assess ventricular function

- e. Notify Pharmacy, Laboratory and Blood Bank regarding plans for CRRT
- f. Epinephrine (continuous drip and low-dose epinephrine syringes) ordered to bedside, in-line, in preparation for BP changes on CRRT; calcium chloride boluses ordered to bedside
- g. Cranial ultrasound to document pre-CRRT/ ECMO evaluation for intracranial hemorrhage, but should never delay therapy

## CLINICAL MANAGEMENT | THERAPEUTICS

**Vascular Access, CRRT, and Metabolic Management detailed below, to occur simultaneously**

### 1. Vascular Access

**Contact Pediatric Surgery Attending on call: 720-777-3999**

- a. Urgent placement of CRRT access expeditiously, at the bedside or in the OR if readily available (within 30 minutes): Transferring to and from OR delays onset of CRRT
  - If delay is expected (greater than 30 minutes), contact back-up surgeon for urgent bedside placement
  - For CRRT without ECMO: 7 Fr double lumen hemodialysis catheter, Right Internal Jugular percutaneous placement preferred to cutdown\*\*
  - **OR** ECMO cannulation, if needed
  - CXR or echocardiography (surgeon preference) to verify position of catheters for use

\*\* these catheters will be heparin locked when not in use for dialysis, refer to CRRT policy for care
- b. Notify nephrology attending on call regarding planned start time for placement of CRRT/ECMO vascular access to facilitate CRRT initiation; CRRT circuit should be primed while access is being obtained to avoid delays in initiation of therapy.
- c. Peripheral arterial access for hemodynamic monitoring required
- d. Additional priority vascular access: separate from CRRT or ECMO catheters, will need minimum of 3 central venous access ports for all medications and therapy (performed by Neonatology); these procedures should be performed expeditiously and not delay therapy
- e. Notify Nephrology attending once vascular access obtained and position verified for use

### 2. CRRT with or without ECMO

**Consult Nephrology Attending on call: 720-777-3999**

If infant is hemodynamically stable, without evidence of impending cardiovascular compromise, proceed to CRRT for ammonia detoxification.

- a. Rapid echocardiography for cardiac function assessment - notify Cardiology fellow for rapid review by Cardiology attending (concise function assessment, not full anatomic echo unless warranted; Cardiology consult in order set to promote rapid study interpretation)

If infant demonstrates refractory hypotension and/or severe ventricular dysfunction, proceed to ECMO with CRRT for ammonia detoxification.

#### CRRT without ECMO

- a. Notify Nephrology attending regarding ETA. Notify NICU CRRT Team Liaisons, Dr. Erica Wymore, (303-520-4770) or Dr. Jason Gien (303-257-2912) for assistance.
- b. NICU Charge Nurse will contact PICU Charge Nurse to arrange CRRT Specialist staffing
- c. CRRT circuit preparation requires minimum of 110 ml PRBCs (to be ordered to bedside for circuit prime by Neonatology service)

- d. Anticoagulation plan (heparin - systemic vs citrate - regional) made between Nephrologist & Neonatology attending based on overall clinical status, hepatic function, risk for intraventricular hemorrhage/bleeding
  - Note that systemic heparin anticoagulation is used most commonly
  - Citrate can cause severe hypocalcemia - optimization of iCa greater than 1.2 mmol/L is critical before CRRT
- e. Expected total preparation time for CRRT circuit is 90 minutes - should be initiated at time of 'Neonatal CRRT' page and primed while access being obtained by Pediatric Surgery; goal to initiate CRRT as soon as vascular access obtained and position verified for use
- f. Nephrology attending will maximize solute clearance to address hyperammonemia, and will adjust dialysate/replacement fluid as clinically indicated
  - Suggested starting dose of dialysis with a dialysis/replacement flow rate of 8,000 ml/1.73 m<sup>2</sup>/hr (1,000 ml/h). Assuming blood flow of 30 mL/min or greater this dose should provide clearance equivalent to intermittent hemodialysis.
  - Concerns regarding recalcitrant hyperammonemia or insufficient ammonia clearance should be discussed with Nephrology attending
- g. Need for continuation of ammonia scavenger medications **during** dialysis to prevent rebound hyperammonemia will be determined by IMD attending

## CRRT with ECMO

- a. Notify Neonatal ECMO Director - Dr. Jason Gien (303-257-2912) or Dr. John Kinsella (303-886-7290); update Nephrology regarding clinical status warranting ECMO
- b. ECMO order set in Epic for blood products, lab schedule, etc. Note blood for priming ECMO circuit is in addition to, and is separate from blood required for CRRT circuit
- c. NICU Charge Nurse will update PICU Charge Nurse regarding ECMO need with CRRT
- d. Expected total preparation time for CRRT circuit is 90 minutes – preparation should be initiated at time of NH page and performed while access being obtained by Pediatric Surgery
  - Utilize protocol in place for CRRT in-line with ECMO circuit, heparinization occurs via ECMO circuit
- e. Concerns for recalcitrant hyperammonemia or insufficient ammonia clearance/detoxification on ECMO should be discussed with Nephrology and ECMO team leaders, to optimize blood flow rates and CRRT/ECMO configuration

Joint decision between Neonatology, Nephrology and IMD services regarding when dialytic support can be terminated and transition to sole medical therapy is appropriate. Option to also adjust CRRT flow rates to reduce clearance while still on CRRT to assess rebound effect (preferable to discontinuing CRRT and requiring re-initiation with a new circuit).

## 3. Metabolic Management

**Consult IMD Attending on call:** 720-777-3999

Basic steps in initial management should be discussed with IMD attending

### Intravenous Fluids and Medications

- a. NPO - to halt protein and fat intake
- b. High caloric IV intake = **Goal 120 kcal/kg/day** to avoid catabolic state which increases protein catabolism and ammonia production
  - Maintenance IV fluids with dextrose 20% (D20W) or greater: total fluid rate at least 120 ml/kg/day to achieve caloric goal
  - Given potential for cerebral edema in setting of hyperammonemia, avoid fluid overload

- Serum glucose 120-170 mg/dl may be needed to promote anabolism; consider insulin if needed (especially in organic acidemias, may be associated with recalcitrant hyperglycemia)
  - Hold sodium in maintenance IV fluids and follow sodium in serum: ammonia scavengers have high sodium content; may be preferable to use maintenance IV fluids with minimal sodium to maintain sodium in normal/high normal range
  - Acid-base status: respiratory alkalosis is a common finding in UCD (ammonia is a primary respiratory stimulant); metabolic acidosis is typically the prominent feature in OA. Acidosis should correct as hyperammonemia corrects and should not be routinely treated e.g. sodium bicarbonate
  - No protein in TPN: typical approach to exclude natural protein for first 18-24 hours of ammonia detoxification, with gradual reintroduction of protein as guided and at the discretion of the IMD physician and IMD nutritionist
  - Lipid emulsion (Intralipid): clinical need determined by IMD attending (await acylcarnitine profile and other biochemical test results to rule out) - start 20% lipid emulsion at 2g/kg/day and may increase in setting of urea cycle defect or organic acidemia
- c. Give IV Arginine
- Loading dose 250 mg/kg IV over 90 minutes
  - Maintenance dose 250 mg/kg IV over 24 hours immediately after completion of loading dose
  - Note **hypotension** as common side effect
  - Central line recommended for infusion, compatible with sodium benzoate/sodium phenylacetate (Ammonul) and dextrose 10% (D10W), verify with Pharmacy
  - May continue to administer through CRRT
- d. Give IV Sodium Benzoate/Sodium Phenylacetate (Ammonul)
- Loading dose 250 mg/kg IV over 90 minutes
  - Maintenance dose 250 mg/kg IV over 24 hours immediately after completion of loading dose
  - Central line recommended for infusion, compatible with arginine and dextrose 10% (D10W), verify with Pharmacy
  - May continue to administer through CRRT
- e. Give Levocarnitine 200-400 mg/kg/day, at discretion of IMD attending
- f. Consider Hydroxocobalamin 1 mg IM/SC once daily, especially if high or emerging suspicion of organic acidemia/disorder of cobalamin metabolism, at discretion of IMD attending
- g. Pressor support that should be readily available due to CRRT and/or arginine effects
- Epinephrine drip
  - Low-dose epinephrine syringes available at bedside
  - Calcium chloride bolus available at bedside
  - If infant arrives/escalates to pressor support prior to CRRT, anticipate 2<sup>nd</sup> and 3<sup>rd</sup> line pressor support and order to bedside to be in-line prior to CRRT initiation

### Additional Considerations

Dependent upon specific etiology of metabolic disorder:

Initiation of lipid emulsion after FAOD excluded, or if UCD/OA more strongly suspected

- a. Intralipid 20% at 2g/kg/day to start and may increase as needed for high caloric goal intake; follow triglyceride levels and lipase levels if receiving high dose lipids

- b. Consider abdominal ultrasound with Doppler of portal vein for evaluation of portosystemic shunt or thrombosis, in possible transient hyperammonemia of the newborn (THAN), especially with unexpectedly slow ammonia clearance despite optimal therapy and optimization of CRRT/ECMO circuit
- c. Timing and method of reintroduction of enteral or parenteral protein is at the discretion of the IMD physician and nutritionist on service

## LABORATORY STUDIES | IMAGING

### Laboratory Studies

#### Notify laboratory of frequent samples to be performed urgently

#### 1. Admission Studies

Utilize iSTAT for ABG/iCa/HCT

- a. Order STAT blood type and crossmatch - needed for CRRT/ ECMO priming
- b. ABG, CBC with differential, CMP, ammonia, lactate, magnesium, phosphorus, ionized calcium, coagulation studies; quantitative plasma amino acids
  - Please call Biochemical Genetics Laboratory (720-777-0525) to expedite plasma amino acids and urine organic acids. Data from these tests will be of diagnostic help in differentiating between OA, UCD, and FAOD, and for differentiating between different subtypes of UCD, which may affect dosing of ammonia scavengers (see Haberle et al. 2012 or Ammonul package insert). Low or low normal glutamine is often seen in OA, but very high glutamine is more likely in UCD
- c. Urinalysis (for ketones), urine organic acids, urine orotic acid

#### 2. Second Tier of Laboratory Investigation

#### Please draw before initiating ECMO and/or CRRT

- a. Acylcarnitine profile
- b. Pyruvate
- c. Total and free carnitine
- d. CK, homocysteine
- e. Blood for Molecular Consultation - formerly known as "Extraction and hold DNA" to allow for genetic testing if needed; 2ml purple top/EDTA tube

#### 3. Laboratory Schedule

- a. Q1-2h plasma ammonia initially and glucose, to be spaced per IMD service
- b. Q3-6h blood gas, electrolytes, phosphorus, magnesium, calcium
- c. Daily CBC and coagulation studies
- d. Daily CMP, triglycerides
- e. Plasma amino acids (holding enteral/intravenous protein sources for 2 hours prior to sampling)
- f. Consider daily lipase if on high dose lipid emulsion or possible emerging clinical features of acute pancreatitis

### Imaging

See [imaging considerations](#) for metabolic management

### CONSENT

Obtain consent from parents for:

- Blood products (urgent Type & Cross)
- CRRT Consent for Children Weighing 20 Kilograms or Less (on CHCO intranet: [English](#), [Spanish](#))
- Surgical procedure for placement of catheter(s)

### REFERENCES

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Spinale et al. High-dose continuous renal replacement therapy for neonatal hyperammonemia. Ped Nephrol 2013; 28(6):983-986.




**CLINICAL IMPROVEMENT TEAM MEMBERS**

- Erica Wymore, MD** | Neonatology
- Austin Larson, MD** | Inherited Metabolic Diseases
- Jennifer Lusk, RN** | CRRT Program Coordinator
- Missy Hanna, MD** | Nephrology
- David Partrick, MD** | Pediatric Surgery
- Michael Murphy, PharmD** | Pharmacy
- Sheila Kaseman, RN** | Clinical Practice Specialist
- Jason Gien, MD** | Neonatology
- Alan Bielsky, MD** | Anesthesia

**APPROVED BY**

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 Pharmacy & Therapeutics Committee – 1/10/2019

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**REVIEW | REVISION SCHEDULE**

Scheduled for full review on 1/10/2023

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