Overview

Useful For
Assessing liver function

Evaluating a wide range of diseases affecting the production, uptake, storage, metabolism, or excretion of bilirubin

Monitoring the efficacy of neonatal phototherapy

Profile Information

<table>
<thead>
<tr>
<th>Test ID</th>
<th>Reporting Name</th>
<th>Available Separately</th>
<th>Always Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILIT</td>
<td>Bilirubin Total, S</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>BILID</td>
<td>Bilirubin, Direct</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Method Name
Total Bilirubin: Photometric, Diazonium Salt

Direct Bilirubin: Colormetric Diazo Method

NY State Available
Yes

Specimen

Specimen Type
Serum

Shipping Instructions
Ship specimen in amber vial to protect from light.

Necessary Information
Patient's age and sex are required.

Specimen Required
Supplies: Amber Frosted Tube, 5 mL (T192)

Collection Container/Tube:

Preferred: 2 Serum gel Microtainers

Acceptable: 2 Red top Microtainers

Submission Container/Tube: Amber vial (T192)

Specimen Volume: 0.5 mL
Test Definition: NBILI
Neonatal Bilirubin, S

Collection Instructions:

1. Serum gel Microtainers should be centrifuged within 2 hours of collection.

2. Red-top Microtainers should be centrifuged and aliquoted within 2 hours of collection.

Specimen Minimum Volume

0.25 mL

Reject Due To

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
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<tbody>
<tr>
<td>Hemolysis</td>
<td>Mild reject; Gross reject</td>
</tr>
<tr>
<td>Lipemia</td>
<td>NA</td>
</tr>
<tr>
<td>Icterus</td>
<td>NA</td>
</tr>
<tr>
<td>Other</td>
<td>NA</td>
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Specimen Stability Information

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Temperature</th>
<th>Time</th>
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<tbody>
<tr>
<td>Serum</td>
<td>Refrigerated (preferred)</td>
<td>24 hours</td>
</tr>
<tr>
<td></td>
<td>Frozen</td>
<td>30 days</td>
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<tr>
<td></td>
<td>Ambient</td>
<td>6 hours</td>
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Clinical and Interpretive

Clinical Information

Bilirubin is one of the most commonly used tests to assess liver function. Approximately 85% of the total bilirubin produced is derived from the heme moiety of hemoglobin, while the remaining 15% is produced from RBC precursors destroyed in the bone marrow and from the catabolism of other heme-containing proteins. After production in peripheral tissues, bilirubin is rapidly taken up by hepatocytes where it is conjugated with glucuronic acid to produce bilirubin mono- and diglucuronide, which are then excreted in the bile.

A number of inherited and acquired diseases affect one or more of the steps involved in the production, uptake, storage, metabolism, and excretion of bilirubin. Bilirubinemia is frequently a direct result of these disturbances.

The most commonly occurring form of unconjugated hyperbilirubinemia is that seen in newborns and referred to as physiological jaundice.

The increased production of bilirubin, that accompanies the premature breakdown of erythrocytes and ineffective erythropoiesis, results in hyperbilirubinemia in the absence of any liver abnormality.

The rare genetic disorders, Crigler-Najjar syndromes type I and type II, are caused by a low or absent activity of bilirubin UDP-glucuronyl-transferase. In type I, the enzyme activity is totally absent, the excretion rate of bilirubin is greatly reduced and the serum concentration of unconjugated bilirubin is greatly increased. Patients with this disease may die in infancy owing to the development of kernicterus.

In hepatobiliary diseases of various causes, bilirubin uptake, storage, and excretion are impaired to varying degrees.
Thus, both conjugated and unconjugated bilirubin are retained and a wide range of abnormal serum concentrations of each form of bilirubin may be observed. Both conjugated and unconjugated bilirubins are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater.

**Reference Values**

**DIRECT**

> or =12 months: 0.0-0.3 mg/dL

Reference values have not been established for patients who are <12 months of age.

**TOTAL**

0-6 days: Refer to www.bilitool.org for information on age-specific (postnatal hour of life) serum bilirubin values.

7-14 days: <15.0 mg/dL

15 days to 17 years: < or =1.0 mg/dL

> or =18 years: < or =1.2 mg/dL

**Interpretation**

The level of bilirubinemia that results in kernicterus in a given infant is unknown. In preterm infants, the risk of a handicap increases by 30% for each 2.9 mg/dL increase of maximal total bilirubin concentration. While central nervous system damage is rare when total serum bilirubin (TSB) is <20 mg/dL, premature infants may be affected at lower levels. The decision to institute therapy is based on a number of factors including TSB, age, clinical history, physical examination, and coexisting conditions. Phototherapy typically is discontinued when TSB level reaches 14 to 15 mg/dL.

Physiologic jaundice should resolve in 5 to 10 days in full-term infants and by 14 days in preterm infants.

When any portion of the biliary tree becomes blocked, bilirubin levels will increase.

**Cautions**

Specimens should be protected from light and analyzed as soon as possible.

Grossly hemolyzed specimens should be rejected because hemoglobin inhibits the diazo reaction and falsely decreased results may be seen.

Compounds that compete for binding sites on serum albumin contribute to lower serum bilirubin levels (eg, penicillin, sulfisoxazole, acetylsalicylic acid).

**Supportive Data**

See Individual Unit Codes.

**Clinical Reference**


Test Definition: NBILI
Neonatal Bilirubin, S


Performance

Method Description
Total bilirubin, in the presence of a suitable solubilizing agent, is coupled with 3,5-dichlorophenyl diazonium in a strongly acidic medium. The color intensity of the red azo dye formed is directly proportional to the total bilirubin and can be determined photometrically.(Package insert: Bilirubin Total Gen. 3, 09/2016.Roche Diagnostics, Indianapolis, IN)

Direct bilirubin in the presence of acidified sodium nitrite produces nitrous acid, which reacts with sulfanilic acid (in acidic solution) to form a diazonium salt. The diazotized sulfanilic acid then reacts with bilirubin to form isomers of azobilirubin. In the direct bilirubin assay, only conjugated bilirubin is converted by the diazotized sulfanilic acid. The intensity of the red color of azobilirubin is measured photometrically and is proportional to the direct (conjugated) bilirubin concentration.(Package insert: Cobas Direct Bilirubin, June 2015, Roche Diagnostics, Indianapolis, IN)

PDF Report
No

Day(s) and Time(s) Test Performed
Monday through Sunday; Continuously

Analytic Time
Same day/1 day

Maximum Laboratory Time
2 days

Specimen Retention Time
See Individual Unit Codes.

Performing Laboratory Location
Rochester

Fees and Codes

Fees
- Authorized users can sign in to Test Prices for detailed fee information.
- Clients without access to Test Prices can contact Customer Service 24 hours a day, seven days a week.
- Prospective clients should contact their Regional Manager. For assistance, contact Customer Service.

Test Classification
This test has been cleared or approved by the U.S. Food and Drug Administration and is used per manufacturer's instructions. Performance characteristics were verified by Mayo Clinic in a manner consistent with CLIA requirements.

CPT Code Information
82247-Bilirubin, total
82248-Bilirubin, direct

**LOINC® Information**

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<th>Order LOINC Value</th>
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<tr>
<td>NBILI</td>
<td>Neonatal Bilirubin, S</td>
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