POLICY STATEMENT

The Apgar Score

American Academy of Pediatrics
Committee on Fetus and Newborn
American College of Obstetricians and Gynecologists
Committee on Obstetric Practice

ABSTRACT

The Apgar score provides a convenient shorthand for reporting the status of the newborn infant and the response to resuscitation. The Apgar score has been used inappropriately to predict specific neurologic outcome in the term infant. There are no consistent data on the significance of the Apgar score in preterm infants. The Apgar score has limitations, and it is inappropriate to use it alone to establish the diagnosis of asphyxia. An Apgar score assigned during resuscitation is not equivalent to a score assigned to a spontaneously breathing infant. An expanded Apgar score reporting form will account for concurrent resuscitative interventions and provide information to improve systems of perinatal and neonatal care.

INTRODUCTION

In 1952, Dr Virginia Apgar devised a scoring system that was a rapid method of assessing the clinical status of the newborn infant at 1 minute of age and the need for prompt intervention to establish breathing.1 A second report evaluating a larger number of patients was published in 1958.2 This scoring system provided a standardized assessment for infants after delivery. The Apgar score comprises 5 components: heart rate, respiratory effort, muscle tone, reflex irritability, and color, each of which is given a score of 0, 1, or 2. The score is now reported at 1 and 5 minutes after birth. The Apgar score continues to provide a convenient shorthand for reporting the status of the newborn infant and the response to resuscitation. The Apgar score has been used inappropriately in term infants to predict specific neurologic outcome. Because there are no consistent data on the significance of the Apgar score in preterm infants, in this population the score should not be used for any purpose other than ongoing assessment in the delivery room. The purpose of this statement is to place the Apgar score in its proper perspective.

The neonatal resuscitation program (NRP) guidelines3 state that “Apgar scores should not be used to dictate appropriate resuscitative actions, nor should interventions for depressed infants be delayed until the 1-minute assessment.” However, an Apgar score that remains 0 beyond 10 minutes of age may be useful in determining whether additional resuscitative efforts are indicated.4 The current NRP guidelines3 state that “if there is no heart rate after 10 minutes of complete and adequate resuscitation efforts, and there is no evidence of other causes of newborn compromise, discontinuation of resuscitation efforts may be appropriate. Current data indicate that, after 10 minutes of asystole, newborns are very unlikely to survive, or the rare survivor is likely to survive with severe disability.”

www.pediatrics.org/cgi/doi/10.1542/peds.2006-0325
doi:10.1542/peds.2006-0325

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

Key Words
Apgar score, asphyxia, neurologic outcome, resuscitation, cerebral palsy

Abbreviation
NRP—neonatal resuscitation program

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275). Copyright © 2006 by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists

Downloaded from http://pediatrics.aappublications.org/ by guest on November 7, 2017
Previously, an Apgar score of 3 or less at 5 minutes was considered an essential requirement for the diagnosis of perinatal asphyxia. *Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology,* produced in 2003 by the American College of Obstetricians and Gynecologists in collaboration with the American Academy of Pediatrics, lists an Apgar score of 0 to 3 beyond 5 minutes as one suggestive criterion for an intrapartum asphyxial insult. However, a persistently low Apgar score alone is not a specific indicator for intrapartum compromise. Further, although the score is used widely in outcome studies, its inappropriate use has led to an erroneous definition of asphyxia. Intrapartum asphyxia implies fetal hypercarbia and hypoxemia, which, if prolonged, will result in metabolic acidemia. Because the intrapartum disruption of uterine or fetal blood flow is rarely, if ever, absolute, asphyxia is an imprecise, general term. Descriptions such as hypercarbia, hypoxia, and metabolic, respiratory, or lactic acidemia are more precise for immediate assessment of the newborn infant and retrospective assessment of intrapartum management.

**LIMITATIONS OF THE APGAR SCORE**

It is important to recognize the limitations of the Apgar score. The Apgar score is an expression of the infant’s physiologic condition, has a limited time frame, and includes subjective components. In addition, the biochemical disturbance must be significant before the score is affected. Elements of the score such as tone, color, and reflex irritability partially depend on the physiologic maturity of the infant. The healthy preterm infant with no evidence of asphyxia may receive a low score only because of immaturity.8 A number of factors may influence an Apgar score, including but not limited to drugs, trauma, congenital anomalies, infections, hypoxia, hypovolemia, and preterm birth.9 The incidence of low Apgar scores is inversely related to birth weight, and a low score is limited in predicting morbidity or mortality.8 Accordingly, it is inappropriate to use an Apgar score alone to establish the diagnosis of asphyxia.

**APGAR SCORE AND RESUSCITATION**

The 5-minute Apgar score, and particularly a change in the score between 1 and 5 minutes, is a useful index of the response to resuscitation. If the Apgar score is less than 7 at 5 minutes, the NRP guidelines state that the assessment should be repeated every 5 minutes up to 20 minutes.9 However, an Apgar score assigned during a resuscitation is not equivalent to a score assigned to a spontaneously breathing infant.9 There is no accepted standard for reporting an Apgar score in infants undergoing resuscitation after birth, because many of the elements contributing to the score are altered by resuscitation. The concept of an “assisted” score that accounts for resuscitative interventions has been suggested, but the predictive reliability has not been studied. To describe such infants correctly and provide accurate documentation and data collection, an expanded Apgar score report form is proposed (Fig 1).

**PREDICTION OF OUTCOME**

A low 1-minute Apgar score alone does not correlate with the infant’s future outcome. A retrospective analysis concluded that the 5-minute Apgar score remained a valid predictor of neonatal mortality, but using it to predict long-term outcome was inappropriate.10 On the other hand, another study11 stated that low Apgar scores at 5 minutes are associated with death or cerebral palsy, and this association increased if both 1- and 5-minute scores were low.

An Apgar score at 5 minutes in term infants correlates poorly with future neurologic outcomes. For example, a score of 0 to 3 at 5 minutes was associated with a slightly increased risk of cerebral palsy compared with higher scores.12 Conversely, 75% of children with cerebral palsy had normal scores at 5 minutes.12 In addition, a low 5-minute score in combination with other markers of asphyxia may identify infants at risk of developing seizures (odds ratio: 39; 95% confidence interval: 3.9–392.5).13 The risk of poor neurologic outcomes increases when the Apgar score is 3 or less at 10, 15, and 20 minutes.7

A 5-minute Apgar score of 7 to 10 is considered normal. Scores of 4, 5, and 6 are intermediate and are not markers of increased risk of neurologic dysfunction. Such scores may be the result of physiologic immaturity, maternal medications, the presence of congenital malformations, and other factors. Because of these other conditions, the Apgar score alone cannot be considered evidence or a consequence of asphyxia. Other factors including nonreassuring fetal heart rate monitoring patterns and abnormalities in umbilical arterial blood gases, clinical cerebral function, neuroimaging studies, neonatal electroencephalography, placental pathology, hematologic studies, and multisystem organ dysfunction need to be considered when defining an intrapartum hypoxic-ischemic event as a cause of cerebral palsy.5

**OTHER APPLICATIONS**

Monitoring of low Apgar scores from a delivery service can be useful. Individual case reviews can identify needs for focused educational programs and improvement in systems of perinatal care. Analyzing trends allows assessment of the impact of quality improvement interventions.

**CONCLUSION**

The Apgar score describes the condition of the newborn infant immediately after birth14 and, when properly ap-
APGAR SCORE

<table>
<thead>
<tr>
<th>SIGN</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLOR</td>
<td>Blue or Faint</td>
<td>Acrocyanotic</td>
<td>Completely Pink</td>
</tr>
<tr>
<td>HEART RATE</td>
<td>Absent</td>
<td>&lt;100 minute</td>
<td>&gt;100 minute</td>
</tr>
<tr>
<td>DEFIANCE</td>
<td>No Response</td>
<td>Grimace</td>
<td>Cry or Active Withdrawal</td>
</tr>
<tr>
<td>MUSCLE TONE</td>
<td>Limp</td>
<td>Some Flexion</td>
<td>Active Motion</td>
</tr>
<tr>
<td>RESPIRATION</td>
<td>Absent</td>
<td>Weak Cry</td>
<td>Hypoventilation</td>
</tr>
</tbody>
</table>

TOTAL

Comments:

FRFIGURE 1
Expanded Apgar score form. Record the score in the appropriate place at specific time intervals. The additional resuscitative measures (if appropriate) are recorded at the same time that the score is reported using a check mark in the appropriate box. Use the comment box to list other factors including maternal medications and/or the response to resuscitation between the recorded times of scoring. PPV/NCPAP indicates positive-pressure ventilation/nasal continuous positive airway pressure; ETT, endotracheal tube.

LIASONs
Keith J. Barrington, MD
Canadian Paediatric Society
Gary D.V. Hankins, MD
American College of Obstetricians and Gynecologists
Tonse N.K. Raju, MD, DCH
National Institutes of Health
Kay M. Tomashek, MD, MPH
Centers for Disease Control and Prevention
Carol Wallman, MSN, RNC, NNP
National Association of Neonatal Nurses and Association of Women’s Health, Obstetric and Neonatal Nurses
Laura E. Riley, MD, Past Liaison
American College of Obstetricians and Gynecologists

STAFF
Jim Couto, MA

ACOG COMMITTEE ON OBSTETRIC PRACTICE
*Gary D.V. Hankins, MD, Chairperson
Sarah J. Kilpatrick, MD, Vice-Chairperson
Angela L. Bell, MD
Jeanne M. Coulehan, CNM
Susan Hellerstein, MD
Jack Ludmir, MD
Carol A. Major, MD
Sean McFadden, MD
Susan M. Ramin, MD
Russell R. Snyder, Col, MC, USAF

AAP COMMITTEE ON FETUS AND NEWBORN, 2005–2006
Ann R. Stark, MD, Chairperson
David H. Adamkin, MD
Daniel G. Batton, MD
Edward F. Bell, MD
Vinod K. Bhutani, MD
Susan E. Denson, MD
William A. Engle, MD
*Gilbert I. Martin, MD
Lillian R. Blackmon, MD, Past Chairperson

1446

American Academy of Pediatrics

by guest on November 7, 2017

Downloaded from http://pediatrics.aappublications.org/ by guest on November 7, 2017
REFERENCES

The Apgar Score
American Academy of Pediatrics, Committee on Fetus and Newborn, American College of Obstetricians and Gynecologists and Committee on Obstetric Practice

*Pediatrics* 2006;117;1444
DOI: 10.1542/peds.2006-0325

Updated Information & Services
including high resolution figures, can be found at:
http://pediatrics.aappublications.org/content/117/4/1444

References
This article cites 12 articles, 5 of which you can access for free at:
http://pediatrics.aappublications.org/content/117/4/1444.full#ref-list-1

Subspecialty Collections
This article, along with others on similar topics, appears in the following collection(s):
Committee on Fetus & Newborn
http://classic.pediatrics.aappublications.org/cgi/collection/committee_on_fetus__newborn
Fetus/Newborn Infant
http://classic.pediatrics.aappublications.org/cgi/collection/fetus:newborn_infant_sub
Neurology
http://classic.pediatrics.aappublications.org/cgi/collection/neurology_sub

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
https://shop.aap.org/licensing-permissions/

Reprints
Information about ordering reprints can be found online:
http://classic.pediatrics.aappublications.org/content/reprints
The Apgar Score
American Academy of Pediatrics, Committee on Fetus and Newborn, American College of Obstetricians and Gynecologists and Committee on Obstetric Practice
Pediatrics 2006;117;1444
DOI: 10.1542/peds.2006-0325

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/117/4/1444