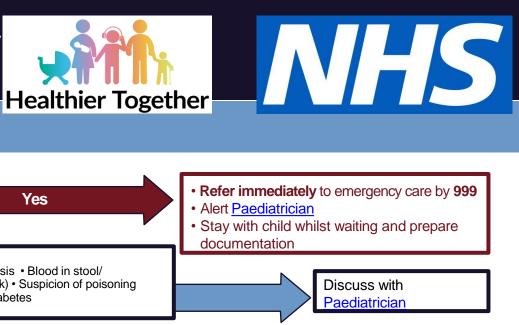
Diarrhoea and/or Vomiting (Gastroenteritis) Pathway

Clinical Assessment / Management for Children with suspected Gastroenteritis





Patient presents with or has a history of diarrhoea and / or vomiting

SUSPECTED GASTROENTERITIS

History Assessment of Vital Signs - Temp, Heart Rate, RR, capillary refill time Consider differential diagnosis Risk factors for dehydration - see Fig 1

Do the symptoms and/or signs suggest an immediately life threatening (high risk) illness?

Consider any of the following as possible indicators of diagnoses other than gastroenteritis: •Fever: Temp > 38°C • Shortness of breath • Altered state of consciousness • Signs of meningism or sepsis • Blood in stool/ Melaena • Bilious (green) or bloody vomit • Vomiting alone • Recent head Injury • Recent burn (toxic shock) • Suspicion of poisoning Severe localised abdominal pain
 Abdominal distension or rebound tenderness/guarding
 Consider diabetes

1 Clinical Findings	Green - Iow risk	Amber - intermediate risk Red - high risk			 Fig 1 Children at increased risk of dehydration are those: Aged <1 year old (and especially the < 6 month age group) Have not taken or have not been able to tolerate fluids before present Infants who have stopped breast feeding during the illness Have vomited three times or more in the last 24 hours Has had six or more episodes of diarrhoea in the past 24 hours 			
Behaviou	 r • Responds normally to social cues • Content / smiles • Stays awake / awakens quickly 	Altered response to social cues No smile						
	 Strong normal crying / not crying 	Decreased activity	Unable to rouse or if ro	Unable to rouse or if roused does not stay awake Weak, high pitched or continuous cry		 History of faltering growth Fig 2 Management of Clinical Dehydration Trial of oral rehydration solution (ORS; can taste better with dilute squa added). 2mls/kg every 10 mins OR 5mls every 5minutes. 		
	• Appears well	Irritable Lethargic						
		Appears unwell			 Consider checking blood glucose, esp in <6 month age group If child fails to improve within 2 hours, refer to paediatrics 			
Skin	Normal skin colourWarm extremitiesNormal turgor	Normal skin colourWarm extremitiesReduced skin turgor	 Pale / mottled / ashen Cold extremities 	 Pale / mottled / ashen blue Cold extremities CRT> 3 secs No urine output for >24 hours Abnormal breathing / tachypnoea* 		 If child fails to improve within 2 hours, feller to paediatrics Reintroduce breast/bottle feeding as tolerated Continue ORS if ongoing losses Consider Ondansetron 0.1mg/kg PO/sublingual (max 4mg) if continued vomiting in context of suspected gastroenteritis If fluids tolerated and clinically improves, move to green actions Fig 3 Management of Clinical Shock Check blood glucose and gas Give 10-20ml/kg 0.9% Saline or Plasmalyte IV/IO If hypoglycaemic give 2ml/kg 10% Dextrose if unconscious or Dextroge Reassess and give further 10-20ml/kg fluid bolus Reassess and liaise with <u>STRS</u> 		
Hydration	 CRT < 2 secs Moist mucous membranes (except after a drine) Fontanelle normal 	 • CRT 2-3 secs • Dry mucous membranes (except for mouth bre • Sunken fontanelle 						
Urine out	put • Normal urine output	Reduced urine output / no urine output for 12 h	ours • No urine output for >24					
Respirato	• Normal breathing pattern and rate*	Normal breathing pattern and rate*	Abnormal breathing / ta			Respiratory Rate at rest: [b/min]	Heart Rate [bpm]	
Heart Rate	Heart rate normal Peripheral pulses normal	 Mild tachycardia* Peripheral pulses normal 	Severe tachycardia*	 Severe tachycardia* Peripheral pulses weak Hypotensive 		30 - 40	110 - 160	
						25 - 35	100 - 150	
	Not sunken	Sunken Eyes Additional parent/carer support required	• Hypotensive			25 - 30 20-25	95 - 140 80-120	
Other						15-20	60-120	
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	Provide Written and Verbal advice (see part Continue with breast and / or bottle feeding Encourage fluid intake, little and often eg. 5m Children at increased risk of dehydration [s Confirm they are comfortable with the decision before sending home.	Agree a management plan with participant of plan with participant. Is every 5 mins Paediatrician.	Begin management of clinical dehydration algorithm [see Fig 2]. Agree a management plan with parents +/- seek advice from <u>Paediatrician</u> .		Refer immediately to emergency care - consider 999 Alert <u>Paediatrician</u> Consider initiating Management of Clinical Dehydration [Fig 2] awaiting transfer Consider commencing high flow oxygen support. If clinical shock suspected or confirmed follow management plan [Fig 3]			

This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and / or carer.