Isotonic Versus Hypotonic Maintenance IV Fluids in Hospitalized Children: A Meta-Analysis

abstract

OBJECTIVE: To assess evidence from randomized controlled trials (RCTs) on the safety of isotonic versus hypotonic intravenous (IV) maintenance fluids in hospitalized children.

METHODS: We searched PubMed, Embase, Cochrane Library, and clinicaltrials.gov (up to April 11, 2013) for RCTs that compared isotonic to hypotonic maintenance IV fluid therapy in hospitalized children. Relative risk (RR), weighted mean differences, and 95% confidence intervals (CIs) were calculated based on the effects on plasma sodium (pNa). The risk of developing hyponatremia (pNa <136 mmol/L), severe hyponatremia (pNa <130 mmol/L), and hypernatremia (pNa >145 mmol/L) was evaluated. We adopted a random-effects model in all meta-analyses. Sensitivity analyses by missing data were also performed.

RESULTS: Ten RCTs were included in this review. The meta-analysis showed significantly higher risk of hypotonic IV fluids for developing hyponatremia (RR 2.24, 95% CI 1.52 to 3.31) and severe hyponatremia (RR 5.29, 95% CI 1.74 to 16.06). There was a significantly greater fall in pNa in children who received hypotonic IV fluids (–3.49 mmol/L versus isotonic IV fluids, 95% CI –5.63 to –1.35). No significant difference was found between the 2 interventions in the risk of hypernatremia (RR 0.73, 95% CI 0.22 to 2.48). None of the findings was sensitive to imputation of missing data.

CONCLUSIONS: Isotonic fluids are safer than hypotonic fluids in hospitalized children requiring maintenance IV fluid therapy in terms of pNa. Pediatrics 2014;133:105–113
Maintenance intravenous (IV) fluids are designed to maintain homeostasis when a patient is unable to uptake required water, electrolytes, and energy. After Holliday and Segar made recommendations for maintenance fluid in children,1 hypotonic fluids are still the most commonly prescribed IV fluids for pediatric hospitalized patients.2–4 Their hypotonic formula was based on the energy expenditure of healthy children and the composition of human breast and cow milk.1 Hypotonic fluids according to their recommendations may be appropriate for healthy children. Nevertheless, they may not be suitable for all hospitalized children.5,6

Hyponatremia, defined as a plasma sodium (pNa) level of <136 mmol/L, draws excess water into cells and causes them to swell. It mainly manifests as central nervous system symptoms such as lethargy, irritability, muscle weakness, seizures, and coma, or even death in the most severe cases.8 Hospitalized children are often in a stressed state and easily secrete excess antiuretic hormone (ADH), which stimulates water retention.9 In this setting, children are prone to develop hyponatremia, especially when receiving hypotonic fluids.9

Accumulating clinical evidence suggests that Holliday and Segar’s recommendations are inappropriate for most hospitalized children.10–20 Clinical evidence suggests that the routine use of hypotonic fluids contributes to the development of iatrogenic hyponatremia, whereas isotonic fluids offer effective prophylaxis against it.10–20 However, traditional guidelines and textbooks continue recommending hypotonic maintenance fluids for pediatric patients.21 Early systematic reviews have evaluated isotonic versus hypotonic maintenance IV fluids in hospitalized children,6,22–24 but only included limited randomized controlled trials (RCTs). Here, we added more recent RCTs to perform an updated systematic review and meta-analysis to address this issue.

METHODS

We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement for reporting of this meta-analysis.25

Search Strategy

We searched PubMed, Embase, Cochrane Controlled Clinical Trials Register, and ClinicalTrials.gov (up to April 11, 2013) for potentially relevant publications without any language restriction. We modified the search strategy from a previous systematic review.6 The detailed search strategy is presented in the Supplemental Information. We also screened references of previous systematic reviews and identified relevant articles.

Study Selection

Two authors independently screened the titles and abstracts of potentially relevant citations. They then read the full texts of citations needing additional evaluation. Discrepancies were resolved through group discussion. The inclusion criteria were as follows:1 studies on RCTs,2 studies on hospitalized children aged from 1 month to 17 years,3 and studies comparing isotonic and hypotonic maintenance IV fluid therapy. Solutions were classified as isotonic if they had the same or near osmotic pressure as blood (eg, 0.9% saline, Hartmann’s solution, or Ringer’s solution) or hypotonic if they had a lower osmotic pressure than blood (eg, 0.45% saline, 0.3% saline, or 0.18% saline). Exclusion criteria were1 non-RCT studies,2 letters and case reports,3 studies published as abstracts only,4 studies involving neonates,5 studies of fluid resuscitation or rehydration,6 and patients with preexisting hyponatremia or comorbidities that resulted in sodium disturbance (eg, renal diseases, liver cirrhosis, congestive heart failure, and diuretic therapies).

Data Extraction

A standard reporting form developed by PRISMA25 was used to extract data. One author extracted data, and another checked all forms. We extracted the following information: methods of the study (as per assessment of risk of bias), characteristics of study population (number, age, and diagnosis), description of the interventions and comparisons, and outcomes. The primary outcome was hyponatremia (pNa <136 mmol/L). Secondary outcomes were severe or symptomatic hyponatremia (pNa <130 mmol/L), pNa and pNa changes after IV fluid therapy, hypernatremia (pNa >145 mmol/L), and adverse events attributable to IV fluid administration and/or pNa derangements (death, cerebral edema, seizures, hypertension, and length of stay).

Assessment of Risk of Bias

We addressed the methodologic quality of included studies using the Cochrane risk-of-bias tool, which includes domains for sequence generation, allocation sequence concealment, blinding, incomplete outcome data, selective outcome reporting, and other potential sources of bias.26 Discrepancies were resolved through group discussion.

Analysis

If ≥1 study reported the same outcome, statistical pooling was adopted to estimate the intervention effects. For dichotomous outcomes, we used relative risk (RR) and 95% confidence intervals (CIs). For continuous outcomes, we used weighted mean differences and 95% CIs. All pooled estimates of the intervention effects
were calculated under a random-effects model. First, we performed analysis of available cases in which data were analyzed for every participant for whom the outcome was obtained. We then performed a sensitivity analysis in which dichotomous data were analyzed according to the intention-to-treat principle, and continuous data were analyzed by assuming a fixed difference between the actual mean for the missing data. Heterogeneity was determined by using the \( I^2 \) statistic and \( I^2 \) values of 0% to 25%, 26% to 49%, 50% to 74%, and 75% to 100% were assigned unimportant, low, moderate, and high heterogeneity, respectively. All statistical analyses were done with RevMan 5.1 (the Cochrane Collaboration, Copenhagen, Denmark).

RESULTS

Study Selection

Figure 1 shows the process of study selection. We identified 10 studies comparing isotonic and hypotonic maintenance IV fluid therapy in hospitalized children according to our criteria. Two were unpublished studies, and we failed to access their data by contacting the authors. Two studies were considered as 4 RCTs because they compared hypotonic and isotonic fluids at 2 maintenance rates. Therefore, 10 RCTs were included in this review.

Study Characteristics

Table 1 shows characteristics of the included RCTs. Five RCTs exclusively enrolled children undergoing surgery, 1 RCT exclusively enrolled children with illnesses that required nonsurgical treatment, and 4 RCTs enrolled both types of patients. The shortest follow-up ranged from 8 to 72 hours.

Risk of Bias

Table 2 shows the risk of bias for each study. Although all studies were reported as RCTs, 3 lacked adequate description in sequence generation and 2 in allocation concealment. Four studies used blinding methods for participants, caregivers, and researchers. 5 studies did not use blinding methods and 1 study reported contradictory data in its abstract and text. One study had a high risk of incomplete outcome data because of a relatively large number of losses during follow-up. Two studies were classified as high risk in the domain of free of selective reporting because they did not report the primary outcome hyponatremia. Four studies were classified as “unclear” because their protocols were unavailable, which made it difficult to make a judgment. Three studies also enrolled participants with preexisting hyponatremia, which may introduce bias in our analysis. One of them supplied separate data for participants of interest for our analysis. The other 2 studies did not supply these data, but their raw data were directly extracted for our analysis considering a small proportion of participants with preexisting hyponatremia.

pNa

All extracted data are presented in Table 3 for meta-analysis of pNa outcomes. Because the study by Kannan et al defined hyponatremia as pNa <130 mmol/L, it was initially excluded in the pooled analysis of hyponatremia. The analysis showed that hypotonic IV fluids significantly increased the risk of hyponatremia (RR 2.24, 95% CI 1.52 to 3.31, \( P < .0001, I^2 = 14\% \), Fig 2). When the study by Kannan et al was included, the result was similar (RR 2.30, 95% CI 1.58 to 3.37, \( P < .0001, I^2 = 12\% \)). In 2 studies, no severe hyponatremia developed in either the isotonic or hypotonic arms. Pooled analysis of other studies with available data showed that hypotonic IV maintenance fluids also significantly increased the risk of severe hyponatremia (RR 5.29, 95% CI 1.74 to 16.06, \( P = .003, I^2 = 0\% \), Fig 3). Mean pNa in children after hypotonic IV fluids was...
significantly lower than those who received isotonic IV fluids (−2.09 mmol/L, 95% CI −2.91 to −1.28, P < .00001, $\hat{I}^2 = 47\%$; Fig 4). Furthermore, the fall in pNa was also significantly greater in children who received hypotonic IV fluids (−3.49 mmol/L, 95% CI −5.63 to −1.35, P = .001, $\hat{I}^2 = 87\%$; Fig 5). However, our analysis showed no significant difference between the 2 interventions in the risk of hyponatremia with or without inclusion of the study by Kannan et al, which defined hyponatremia as pNa > 150 mmol/L (without the study by Kannan et al: RR 0.73, 95% CI 0.22 to 2.48, $P = .62$, $\hat{I}^2 = 0\%$; with the study by Kannan et al: RR 0.98, 95% CI 0.38 to 2.57, $P = .97$, $\hat{I}^2 = 0\%$). Because the studies by Neville et al also enrolled a small proportion of participants with preexisting hyponatremia (0%–6%), we excluded these subjects to see whether they would influence the results. We found that this population did not affect our findings (data not shown).

We also performed a sensitivity analysis to see whether missing data of included studies would influence our findings. For the risks of hyponatremia, severe hyponatremia, and hypernatremia, we extracted intention-to-treat data to perform sensitivity analysis. For pNa and changes in pNa after fluid treatment, we assumed that the missing data in the hypotonic fluid arm had averaged 1 mmol/L higher than the observed data itself, and the missing data in the isotonic fluid arm had

### TABLE 1 Characteristics of Included RCTs of Hypotonic Versus Isotonic Maintenance IV Fluid Therapy in Hospitalized Children

<table>
<thead>
<tr>
<th>Study</th>
<th>Condition</th>
<th>Follow-up, h</th>
<th>Hypotonic Solution</th>
<th>Isotonic Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazel 1996</td>
<td>Surgical</td>
<td>7</td>
<td>Adolescent 0.3% S and 3% D; 0.18% S and 4% D</td>
<td>5 Adolescent Hartman's solution</td>
</tr>
<tr>
<td>Yung 2009a</td>
<td>Surgical and medical</td>
<td>15</td>
<td>47 (1.4–8.9) 0.18% S and 4% D</td>
<td>13 5.3 (0.9–12) 0.9% S</td>
</tr>
<tr>
<td>Yung 2009b</td>
<td>Surgical and medical</td>
<td>11</td>
<td>3.7 (1.5–14.7) 0.18% S and 4% D</td>
<td>11 15.4 (10.8–15.9) 0.9% S</td>
</tr>
<tr>
<td>Kannan 2010</td>
<td>Medical</td>
<td>56</td>
<td>4.0 (1.1–6.0) 0.18% S and 5% D at full rate</td>
<td>58 3.0 (1.0–7.0) 0.9% S and 5% D at full rate</td>
</tr>
<tr>
<td>Neville 2010a</td>
<td>Surgical</td>
<td>24</td>
<td>3.0 (0.8–5.5) 0.18% S and 5% D at 2/3 rate</td>
<td>31 9.4 (1.0–14.9) 0.9% S and 5% D at half rate</td>
</tr>
<tr>
<td>Neville 2010b</td>
<td>Surgical</td>
<td>8</td>
<td>9.1 (0.9–14.9) 0.45% S and 2.5%</td>
<td>31 8.4 (0.6–14.9) 0.9% S and 2.5%</td>
</tr>
<tr>
<td>Choong 2011</td>
<td>Surgical</td>
<td>130</td>
<td>9.2 (1.7–9.9) 0.45% S and 5% D</td>
<td>128 9.2 ± 5.5 0.9% S and 5% D</td>
</tr>
<tr>
<td>Rey 2011</td>
<td>Surgical and medical</td>
<td>62</td>
<td>30–50 mmol/L NaCl and 20 mmol/L KCl</td>
<td>63 4.9 (2.0–10.6) 1.36 mmol/L NaCl and 20 mmol/L KCl</td>
</tr>
<tr>
<td>Saba 2011</td>
<td>Surgical and medical</td>
<td>8</td>
<td>8.9 (1.7–16.5) 0.45% S and 5% D</td>
<td>16 8.2 (2.8–14.3) 0.9% S and 5% D</td>
</tr>
<tr>
<td>Coulthard 2012</td>
<td>Surgical</td>
<td>41</td>
<td>11.5 (6.0–14.1) 0.45% S and 5% D</td>
<td>41 11.3 (4.3–13.9) Hartmann's and 5% D</td>
</tr>
</tbody>
</table>

D, dextrose; KCl, potassium chloride; NaCl, sodium chloride; S, saline.

### TABLE 2 Risk of Bias of Included Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Adequate Sequence Generation</th>
<th>Allocation Concealment</th>
<th>Blinding</th>
<th>Incomplete Outcome Data Addressed</th>
<th>Free of Selective Reporting</th>
<th>Free of Other Bias</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazel 1996</td>
<td>Unclear</td>
<td>Unclear</td>
<td>No</td>
<td>Yes</td>
<td>Unclear</td>
<td>Unclear</td>
<td>Hyponatremia was not reported</td>
</tr>
<tr>
<td>Yung 2009a</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Unclear</td>
<td>Hyponatremia was not reported</td>
</tr>
<tr>
<td>Yung 2009b</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Unclear</td>
<td>Hyponatremia was not reported</td>
</tr>
<tr>
<td>Kannan 2010</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Participants with preexisting hyponatremia (6%)</td>
</tr>
<tr>
<td>Neville 2010a</td>
<td>Unclear</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Unclear</td>
<td>No</td>
<td>Participants with preexisting hyponatremia (6%)</td>
</tr>
<tr>
<td>Neville 2010b</td>
<td>Unclear</td>
<td>No</td>
<td>Yes</td>
<td>Unclear</td>
<td>No</td>
<td>No</td>
<td>Participants with preexisting hyponatremia (0%–6%)</td>
</tr>
<tr>
<td>Choong 2011</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Participants with preexisting hyponatremia (29%–37%)</td>
</tr>
<tr>
<td>Rey 2011</td>
<td>Yes</td>
<td>Unclear</td>
<td>No</td>
<td>Yes</td>
<td>Unclear</td>
<td>No</td>
<td>Postrandomization exclusions (19 of 59 subjects)</td>
</tr>
<tr>
<td>Saba 2011</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td></td>
</tr>
<tr>
<td>Coulthard 2012</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td></td>
</tr>
</tbody>
</table>
averaged 1 mmol/L lower than the observed data itself. The results were similar to those from the analysis of available cases (Table 4).

Heterogeneity was significant in the analysis of pNa and pNa changes with $\hat{I}^2$ value of 47% and 87%, respectively. When the study by Brazel et al was excluded, the $\hat{I}^2$ value became 17% and 0, respectively, and the meta-analysis results remained nearly identical. No significant heterogeneity was present in the analyses of other outcomes.

### Adverse Events

Adverse outcomes of interest were reported in 2 studies. Kannan et al reported 1 death (1.72%, 1/58) in children receiving isotonic fluid for acute respiratory distress syndrome. This child had normal pNa throughout the study period. They also reported 1 case of hyponatremic encephalopathy with seizures and stupor in children receiving hypotonic fluid. Choong et al reported new-onset hypertension in 1.54% (2 of 130) children receiving hypotonic fluid and none in those receiving isotonic fluid. The hospital length of stay was similar between the 2 types of fluids.

### Subgroup Analysis

Two of the included studies determined the effect of administration rate (full rate versus two-thirds rate, and full rate versus half rate) on pNa. Their results showed that fluid type (isotonic or hypotonic solutions), not rate, determined the risk of hyponatremia and hypernatremia; Hypo, hyponatremia; pNa, sodium; N, number of participants expressed as available cases (randomized cases); NA, not available; pNa end, pNa after IV fluids; pNa changes, pNa changes after IV fluids.

### FIGURE 2

Meta-analysis of data for the outcome of hyponatremia comparing hypotonic with isotonic IV maintenance fluids in hospitalized children.

### FIGURE 3

Meta-analysis of data for the outcome of severe hyponatremia comparing hypotonic with isotonic IV maintenance fluids in hospitalized children.
pNa changes, and fluid restriction may not satisfy a child’s daily requirement. Five of the included studies exclusively enrolled children undergoing surgery and 1 exclusively enrolled children with illnesses not requiring surgery. Separate analyses showed that hypotonic solutions were associated with increased risk of hyponatremia in each of the populations (data not shown). Four of the included studies enrolled both surgical and nonsurgical patients. Yung et al found that surgical patients tended to have a greater fall in pNa than nonsurgical patients (−2.3 mmol/L, 95% CI −4.6 to 0.1, \( P = .057 \)). Three studies also evaluated the influence of mechanical ventilation. They found no difference in pNa and pNa changes after fluid treatment between ventilated and nonventilated patients.

**DISCUSSION**

Our systematic review and meta-analysis of isotonic versus hypotonic maintenance IV fluids in hospitalized children act as an update of previous reviews. With 10 published RCTs involving 855 subjects, we confirmed the early finding that hypotonic maintenance IV fluid was a risk factor for hospital-acquired hyponatremia for pediatric patients. The review by Choong et al calculated an odds ratio of 17.2 for developing hyponatremia with hypotonic fluids, which was much higher than ours of 3.49 (RR 2.24). Inclusion of retrospective studies and rehydration RCT was likely to contribute to this disparity. Because severe hyponatremia is more strongly associated with symptoms and complications, we also calculated pooled RR of developing severe hyponatremia, whereas previous reviews did not do so because of lack of data at that time. The meta-analysis showed that hypotonic maintenance IV fluids significantly increased the risk of severe hyponatremia in hospitalized children. Such findings raise the possibility that hypotonic maintenance IV fluids could increase hyponatremia-associated death and severe complications such as hyponatremic encephalopathy. Reports of death or neurologic injury as a result of hospital-acquired hyponatremia in children receiving hypotonic IV fluids are also accumulating. However, in the 855 subjects of the included 10 RCTs, cases developing such severe conditions were too scant to draw a conclusion. One explanation is that such cases are rare and the sample size was not large enough. Another is that participants in the included studies were tested for pNa more frequently than...
those in common practices and therefore were immediately treated before complications occurred.

Hyponatremia occurs due to a deficit in sodium, excessive water intake, or impaired ability to excrete free water. The sodium intakes in each group of the included RCTs were well within the daily requirements. In the healthy state, humans can excrete excessive fluid to maintain sodium and water homeostasis. Therefore, the development of hyponatremia was contributed to the impaired ability to excrete free water when hypotonic fluids were administered.

ADH increases the permeability of collecting duct cells in the kidney, leading to retention of free water. Hospitalized children often have ≥1 stimuli (such as postoperative state, blood loss, vomiting, and pain) for excess ADH. This is thought to contribute to impaired ability to excrete free water. Thus, hypotonic fluids, with more free water than isotonic fluids, are more likely to cause a positive balance of free water in these pediatric patients.

Choong et al observed elevated ADH levels in those developing hospital-acquired hyponatremia regardless of fluid type, suggesting the underlying role of excess ADH in another way. Because of this role, isotonic fluids are not exempt from the risk of developing hyponatremia, although the risk is lower compared with hypotonic fluids.

We are confident in the finding that hypotonic IV fluids were more likely than isotonic IV fluids to cause hyponatremia in hospitalized children. First, the meta-analysis results of hyponatremia, severe hyponatremia, and pNa changes after fluid therapy are consistent. Second, the results from sensitivity analysis by missing data are similar to those using analysis of available cases. Two studies with special situations also did not affect the results. Third, there was no obvious heterogeneity among the included RCTs. The main heterogeneity in the analyses of pNa and pNa changes came from an RCT with a small sample size. Fourth, we adopted a random-effects model in all meta-analyses. This model produces more conserved results than the fixed-effects model. Many observational studies suggested that isotonic fluids are superior to hypotonic fluids in hospitalized children. These studies were not included in the current meta-analysis because they did not meet the predefined criteria. However, the findings from these studies are consistent with our findings. In addition, 1 RCT with a substantial proportion of patients with preexisting hyponatremia at the baseline showed that isotonic fluids could correct preexisting hyponatremia.

The finding that hypotonic IV fluids were more likely than isotonic IV fluids to develop hyponatremia in hospitalized children may be applicable to a range of settings: restricted fluids or fluids at full rate, medical or surgical patients, and receiving or not receiving mechanical ventilation. Yung et al observed a greater fall of pNa in surgical patients than in medical patients, but their study lacked a description of medical conditions and hyponatremia is common in patients with infection (especially severe infection) and pulmonary disease. In surgical patients, it is not uncommon to develop hyponatremia in the postoperative state because of the multiple stimuli for ADH that are present, such as subclinical fluid deficit, pain, nausea, vomiting, and narcotic use. Most participants in this meta-analysis were surgical pediatric patients. Thus, our findings are more applicable to this population.

The strength of the review was based on a comprehensive search strategy, explicit criteria for selection of relevant studies, assessment of risk of bias, data analysis strictly following the Cochrane Handbook, and the compliance of the report with the PRISMA guidelines. All included studies were RCTs, making the evidence stronger than previous reviews. However, we note 2 caveats regarding this review. First, only published studies were included. This may introduce a publication bias. Another is the presence of obvious variances among patient characteristics including differing IV fluid types such as 0.45% saline and 0.18% saline, formulas for calculating the rate of IV fluids in different studies, durations of administration, and study quality. Additionally, the sample size was small in most included studies.

Overall, isotonic fluids are safer than hypotonic fluids in hospitalized children requiring maintenance IV fluid therapy in terms of pNa levels. However, there is no ideal IV fluid for all children in terms of composition of fluid (0.9% saline/Hartmann’s, etc) and the rate and duration of administration. pNa needs to be monitored when IV fluids are administered. At present, isotonic fluids may be a better choice than the traditional recommendations.
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**ANOTHER EXAM:** My eldest son is in his fourth year of college. He has taken a circuitous route through college, but plans to enter the workforce after graduating next spring. Given that the job market for someone with an East Asian history major is fairly limited, he plans to take an exam to prove that he can think on his feet. As reported in *The Wall Street Journal* (U.S. News: August 25, 2013), many graduating college students now take the Collegiate Learning Assessment (CLA) examination. The 90-minute examination (which is benchmarked and uses the same numerical scoring system as the SAT exam) assesses critical thinking, analytical reasoning, documents literacy, and writing and communication but not subject-specific material. Employers like the test as it may be a better way to assess applicant skills. Many employers do not believe that colleges have prepared students for jobs in the current marketplace and that grade point averages are a poor proxy for intelligence or problem-solving skills (and do not correlate with job performance). Students who take Massive Open Online Courses with limited credit are also likely to benefit as they can prove that they can apply what they have learned. Seeing an opportunity, a few organizations are now offering national, benchmarked assessments of clinical reasoning skills for graduating students. I do not know how the university he attends feels about the examination. I, however, do wish that several years of tuition and learning experiences were worth more than a 90-minute examination.

*Noted by WVR, MD*
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