Practice Parameter: The Management of Acute Gastroenteritis in Young Children

Provisional Committee on Quality Improvement, Subcommittee on Acute Gastroenteritis

This practice parameter formulates recommendations for health care providers about the management of acute diarrhea in children ages 1 month to 5 years. It was developed through a comprehensive search and analysis of the medical literature. Expert consensus opinion was used to enhance or formulate recommendations where data were insufficient.

The Provisional Committee on Quality Improvement of the American Academy of Pediatrics (AAP) selected a subcommittee composed of pediatricians with expertise in the fields of gastroenterology, infectious diseases, pediatric practice, and epidemiology to develop the parameter. The subcommittee, the Provisional Committee on Quality Improvement, a review panel of practitioners, and other groups of experts within and outside the AAP reviewed and revised the parameter. Three specific management issues were considered: (1) methods of rehydration, (2) refeeding after rehydration, and (3) the use of antidiarrheal agents. Main outcomes considered were success or failure of rehydration, resolution of diarrhea, and adverse effects from various treatment options. A comprehensive bibliography of literature on gastroenteritis and diarrhea was compiled and reduced to articles amenable to analysis.

Oral rehydration therapy was studied in depth; inconsistency in the outcomes measured in the studies interfered with meta-analysis but allowed for formulation of strong conclusions. Oral rehydration was found to be as effective as intravenous therapy in rehydrating children with mild to moderate dehydration and is the therapy of first choice in these patients. Refeeding was supported by enough comparable studies to permit a valid meta-analysis. Early refeeding with milk or food after rehydration does not prolong diarrhea; there is evidence that it may reduce the duration of diarrhea by approximately half a day and is recommended to restore nutritional balance as soon as possible. Data on antidiarrheal agents were not sufficient to demonstrate efficacy; therefore, the routine use of antidiarrheal agents is not recommended, because many of these agents have potentially serious adverse effects in infants and young children.

This practice parameter is not intended as a sole source of guidance in the treatment of acute gastroenteritis in children. It is designed to assist pediatricians by providing an analytic framework for the evaluation and treatment of this condition. It is not intended to replace clinical judgment or to establish a protocol for all patients with this condition. It rarely will provide the only appropriate approach to the problem. A technical report describing the analyses used to prepare this parameter and a patient education brochure are available through the Publications Department of the AAP.

BACKGROUND

Although most children with gastroenteritis who live in developed countries have mild symptoms and little or no dehydration, a substantial number will have more severe disease. In the United States, an average of 220,000 children younger than 5 years are hospitalized each year with gastroenteritis, accounting for more than 900,000 hospital days. Approximately 9% of all hospitalizations of children younger than 5 years are because of diarrhea.1 In addition, approximately 300 children younger than 5 years die each year of diarrhea and dehydration (R. I. Glass, written communication, February 1995). Clinicians should be aware that young infants who were premature and children of teenaged mothers who have not completed high school, had little or no prenatal care, and belong to minority groups are at higher risk of death caused by diarrhea (R. I. Glass, written communication, February 1995).

In the United States, the incidence of diarrhea in children younger than 3 years has been estimated to be 1.3 to 2.3 episodes per child per year; rates in children attending day care centers are higher.2 Hospitalization and outpatient care for pediatric diarrhea result in direct costs of more than $2.0 billion per year.3-5 There are also indirect costs to families. Surveys show that many health care providers do not follow recommended procedures for management of this disorder.6 This practice parameter is intended to present current knowledge about the optimal treatment of children with diarrhea.

Children Covered by the Parameter

In this practice parameter, acute gastroenteritis is defined as diarrheal disease of rapid onset, with or without accompanying symptoms and signs, such as nausea, vomiting, fever, or abdominal pain. Although the emphasis of this parameter is on diar-
rhea, vomiting can be an important component of gastroenteritis and is addressed specifically below. These recommendations apply to children 1 month to 5 years of age who live in developed countries and who have no previously diagnosed disorders, including immunodeficiency, affecting major organ systems. Episodes of diarrhea lasting longer than 10 days, diarrhea accompanying failure to thrive, and vomiting with no accompanying diarrhea are not addressed. Although most patients meeting the criteria of this parameter will have viral or self-limited bacterial diarrhea, children with bacterial dysentery or protozoal disease can be treated according to the principles presented herein but may benefit from specific antimicrobial therapy.

Outcomes Studied

The major outcomes studied in this analysis of management options were success or failure of rehydration, resolution of diarrhea, and adverse effects of antidiarrheal agents.

Target Audience and Settings

This parameter was designed to aid physicians, nurse practitioners, physician assistants, nurses, and other health care providers who care for children with acute diarrheal disease in outpatient and inpatient settings. It is meant to guide treatment of such children; clinical judgment guided by the special circumstances of each situation will determine the ultimate care of any individual child and may vary from the management outlined herein.

Sources of Information

Ideally, medical information and recommendations are derived from well-designed, properly analyzed scientific studies. When such data are not available on a given subject, consensus may be obtained from experts in the field. In this parameter, three specific topics have received in-depth analysis: rehydration, reintroduction of feeding, and the use of medications designed to influence diarrhea and to provide symptomatic relief. These issues were chosen because of their importance in the management of diarrhea, because there is evidence that practitioners need more information in these areas, and because data are available for study.

In researching these key aspects of the management of acute gastroenteritis, references were identified through MEDLINE searches using the terms gastroenteritis, diarrhea, and diarrhea, infantile to provide an initial, broad database of articles. In addition, specific MEDLINE searches were conducted for various antidiarrheal agents. To supplement the MEDLINE results, articles also were obtained from a number of other sources, including personal files of subcommittee members, bibliographies of articles identified through the computer search, the Centers for Disease Control and Prevention report on management of acute diarrhea in children, the Federal Register notice, and a petition to the Food and Drug Administration from the consumer group Public Citizen (written communication, January 1993). More than 4000 articles were included on the original list; after evaluation for relevance and validity, 230 articles were selected for complete review.

Sufficient randomized trials with similar outcomes performed in developed countries were available on early refeeding to allow the combining of results for meta-analysis. Many controlled studies on oral rehydration therapy (ORT) in developed countries were available, but the outcomes of these studies varied; it was not possible to combine their results quantitatively. Many trials on ORT performed in developing countries were available but were not included in this analysis. Few studies on specific antidiarrheal agents were available, although the committee examined reports on drug therapy from developing as well as developed countries. Recommendations have been drawn from analysis of available literature and have been augmented by expert consensus opinion. The sources and validity of data underlying the committee’s conclusions are indicated. Further details on the literature review and analysis are available in the technical report. An abstract of the technical report follows this practice parameter.

Other clinical decisions must be addressed when treating children with gastroenteritis, eg, when to obtain stool cultures, the appropriate use of antibiotics, and the prevention of diarrhea. Extensive evaluation of these issues has not been included as part of this parameter. For additional information, the reader is referred to the general review articles that address many of these issues in detail.

REHYDRATION AND REFEEDING: SCIENTIFIC BACKGROUND

ORT

Recommendation. ORT is the preferred treatment of fluid and electrolyte losses caused by diarrhea in children with mild to moderate dehydration (based on evaluation of controlled clinical trials documenting the effectiveness of ORT; an explanation of what constitutes a recommendation can be found in the technical report).

Replacement of fluid and electrolyte losses is the critical central element of effective treatment of acute diarrhea. Beginning with initial studies conducted 150 years ago, investigators have demonstrated that stool losses of water, sodium, potassium, chloride, and base must be restored to ensure effective rehydration.9–11 Approximately 60 years ago, intravenous (IV) therapy became the first successful routine method of administration of fluid and electrolytes and was widely accepted as the standard form of rehydration therapy.12 The treatment of diarrhea was advanced further in the mid-1960s with the discovery of coupled transport of sodium and glucose (or other small, organic molecules), providing scientific justification for ORT as an alternative to IV therapy.12 ORT has obvious potential advantages over IV therapy; it is less expensive and can be administered in many settings, including at home by family members. The first studies comparing oral glucose-electrolyte solutions with standard IV therapy were conducted successfully in patients with cholera in Bangladesh and India in the late 1960s.13,14 The solu-
tions used were similar to the oral rehydration salt solution recommended by the World Health Organization and the United Nations Children's Fund that has been used successfully throughout the world for more than 20 years.

During the past decade, a series of studies from developed countries has proved the effectiveness of ORT compared with IV therapy in children with diarrhea from causes other than cholera. These studies evaluated glucose-electrolyte ORT solutions with sodium concentrations ranging from 50 to 90 mmol/L compared with rapidly administered IV therapy. These ORT solutions successfully rehydrated more than 90% of dehydrated children and had lower complication rates than those for IV therapy. The cost of ORT, when hospitalization can be spared, is substantially less than that of IV therapy, but the frequency of stools, duration of diarrhea, and rate of weight gain are similar with both therapies.

A variety of oral solutions are available in the United States (Table 1). Most readily available commercially and used most commonly have sodium concentrations ranging from 45 to 50 mmol/L, which is at or just less than the lower concentration of the solutions studied. Although these products are best suited for use as maintenance solutions, they can rehydrate satisfactorily otherwise healthy children who are mildly or moderately dehydrated. Glucose-electrolyte solutions such as these, which are formulated on physiologic principles, must be distinguished from other popular but nonphysiologic liquids that have been used inappropriately to treat children with diarrhea (Table 2). These beverages have inappropriately low electrolyte concentrations for ORT use and are hypertonic, owing to their high carbohydrate content. Parents should be discouraged from using nonphysiologic solutions to treat children with diarrhea.

Although glucose-electrolyte ORT is extremely effective in replacing fluid and electrolyte losses, it has no effect on stool volume or the duration of diarrhea. To address this limitation, investigators have administered cereal-based solutions that include naturally occurring food polymers from starch, simple proteins, and a variety of other substrates. Starch and simple proteins provide more cotransport molecules for ORT use and are hypertonic, owing to their high carbohydrate content. Parents should be discouraged from using nonphysiologic solutions to treat children with diarrhea.

A meta-analysis was performed to evaluate the use of lactose-containing feedings in children with diarrhea and concluded that 80% or more of children with acute diarrhea can tolerate full-strength milk safely. Although reduction in intestinal brush-border lactase levels is often associated with diarrhea, most infants with decreased lactase levels will not be dehydrated. Children who have diarrhea and are not dehydrated should continue to be fed age-appropriate diets. Children who require rehydration should be fed age-appropriate diets as soon as they have been rehydrated (based on evaluation of controlled clinical studies documenting the benefits of early feeding of liquid and solid foods).

Optimal oral therapy regimens have incorporated early feeding of age-appropriate foods as an integral component. When used with glucose-electrolyte ORT, early feeding can reduce stool output as much as cereal-based ORT can. A variety of early feeding regimens have been studied, including human milk, diluted and full-strength animal milk and animal milk formulas, diluted and full-strength lactose-free formulas, and staple food diets with milk. These studies have demonstrated that unrestricted diets do not worsen the course or symptoms of mild diarrhea and can decrease stool output compared with ORT or IV therapy alone. The literature from developed countries on early refeeding allows for meta-analysis, which shows that the duration of diarrhea may be reduced by 0.43 days (95% confidence interval, −0.74 to −0.12). Although these beneficial effects are modest, of major importance is the added benefit of improved nutrition with early feeding.

A meta-analysis was performed to evaluate the use of lactose-containing feedings in children with diarrhea and concluded that 80% or more of children with acute diarrhea can tolerate full-strength milk safely. Although reduction in intestinal brush-border lactase levels is often associated with diarrhea, most infants with decreased lactase levels will not have inappropriately low electrolyte concentrations for ORT use and are hypertonic, owing to their high carbohydrate content. Parents should be discouraged from using nonphysiologic solutions to treat children with diarrhea.

**TABLE 1. Composition of Representative Glucose-Electrolyte Solutions**

<table>
<thead>
<tr>
<th>Solution</th>
<th>CHO, mmol/L</th>
<th>Na, mmol/L</th>
<th>K, mmol/L</th>
<th>Base, mmol/L</th>
<th>Osmolality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naturalyte (unlimited beverage)</td>
<td>140</td>
<td>45</td>
<td>20</td>
<td>48</td>
<td>265</td>
</tr>
<tr>
<td>Pediatric electrolyte (NutraMax)</td>
<td>140</td>
<td>45</td>
<td>20</td>
<td>30</td>
<td>250</td>
</tr>
<tr>
<td>Pedialyte (Ross)</td>
<td>140</td>
<td>45</td>
<td>20</td>
<td>30</td>
<td>250</td>
</tr>
<tr>
<td>Infalyte (formerly Ricelyte; Mead Johnson)</td>
<td>70</td>
<td>50</td>
<td>25</td>
<td>30</td>
<td>200</td>
</tr>
<tr>
<td>Rehydralyte (Ross)</td>
<td>140</td>
<td>75</td>
<td>20</td>
<td>30</td>
<td>310</td>
</tr>
<tr>
<td>WHO/UNICEF oral rehydration salt†</td>
<td>111</td>
<td>90</td>
<td>20</td>
<td>30</td>
<td>310</td>
</tr>
</tbody>
</table>

† Available from Jainmas Bros Packaging Co, 2530 SW Blvd, Kansas City, MO 64108.
The question of which foods are best for refeeding has been an issue of continuing study. Although agreement is not universal, clinical experience based on controlled clinical trials suggests that certain foods, including complex carbohydrates (rice, wheat, potatoes, bread, and cereals), lean meats, yogurt, fruits, and vegetables, are better tolerated.24-25,36,37 Fatty foods or foods high in simple sugars (including tea, juices, and soft drinks) should be avoided.7 Note that this is not the classic BRAT diet, which consists of bananas, rice, applesauce, and toast. Although these foods can be tolerated, this limited diet is low in energy density, protein, and fat.

### REHYDRATION AND REFEEDING: MANAGEMENT GUIDELINES

The following therapeutic recommendations are based on the evaluation of available literature augmented by expert opinion, as described in previous sections. These recommendations are presented in schematic form in the algorithm.

**General Considerations**

**Evaluation of Dehydration**

Available published data have provided rigorous justification for the principles of ORT for diarrhea. Successful implementation of ORT starts with an evaluation of the child’s degree of dehydration. Guidelines for assessment of dehydration and rehydration are listed in Table 3. If an accurate recent weight is available, determination of the percentage of weight lost is an objective measure of dehydration. Capillary refill time can be a helpful adjunctive measure to determine the degree of dehydration.41 Although refill can be affected by fever, ambient temperature, and age,42 the clinician should consider delayed capillary refill to be a sign of significant dehydration until proven otherwise. Urinary output and specific gravity are helpful measures to confirm the degree of dehydration and to determine that rehydration has been achieved. Parents should be taught the natural history of diarrhea and the signs of dehydration.

**Electrolyte Measurement**

Most episodes of dehydration caused by diarrhea are isonatremic, and serum electrolyte determinations are unnecessary. Electrolyte levels should be measured in moderately dehydrated children whose histories or physical findings are inconsistent with straightforward diarrheal episodes and in all severely dehydrated children. Clinicians should be aware of the features of hypernatremic dehydration, which can lead to neurologic damage and which

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### TABLE 2. Composition of Representative Clear Liquids Not Appropriate for Oral Rehydration Therapy*

<table>
<thead>
<tr>
<th>Liquid</th>
<th>CHO, mmol/L</th>
<th>Na, mmol/L</th>
<th>K, mmol/L</th>
<th>Base, mmol/L</th>
<th>Osmolality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cola</td>
<td>700 (F,G)</td>
<td>2</td>
<td>0</td>
<td>13</td>
<td>750</td>
</tr>
<tr>
<td>Apple juice</td>
<td>690 (F,G)</td>
<td>3</td>
<td>32</td>
<td>0</td>
<td>730</td>
</tr>
<tr>
<td>Chicken broth</td>
<td>0</td>
<td>250</td>
<td>8</td>
<td>0</td>
<td>500</td>
</tr>
<tr>
<td>Sports beverage</td>
<td>255 (S,G)</td>
<td>20</td>
<td>3</td>
<td>3</td>
<td>330</td>
</tr>
</tbody>
</table>

* Adapted from Snyder J. The continuing evolution of oral therapy for diarrhea. Semin Pediatr Infect Dis. 1994;5:231-235. CHO, carbohydrate; F, fructose; G, glucose; K, potassium; Na, sodium; S, sucrose.

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### TABLE 3. Assessment of Dehydration*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mild, 3%-5%</th>
<th>Moderate, 6%-9%</th>
<th>Severe, ≥10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>Normal</td>
<td>Normal or slightly decreased</td>
<td>Normal to reduced</td>
</tr>
<tr>
<td>Quality of pulses</td>
<td>Normal</td>
<td>Increased</td>
<td>Moderately decreased</td>
</tr>
<tr>
<td>Heart rate</td>
<td>Normal</td>
<td>Decreased</td>
<td>Increased†</td>
</tr>
<tr>
<td>Skin turgor</td>
<td>Normal</td>
<td>Sunken</td>
<td>Decreased</td>
</tr>
<tr>
<td>Fontanelle</td>
<td>Normal</td>
<td>Dry</td>
<td>Sunken</td>
</tr>
<tr>
<td>Mucous membranes</td>
<td>Slightly dry</td>
<td>Sunken orbits</td>
<td>Deeply sunken orbits</td>
</tr>
<tr>
<td>Eyes</td>
<td>Normal</td>
<td>Delayed capillary refill</td>
<td>Cool, mottled</td>
</tr>
<tr>
<td>Extremities</td>
<td>Warm, normal capillary refill</td>
<td>Normal to listless</td>
<td>Normal to lethargic or comatose</td>
</tr>
<tr>
<td>Mental status</td>
<td>Normal</td>
<td>&lt;1 mL/kg/h</td>
<td>&lt;1 mL/kg/h</td>
</tr>
<tr>
<td>Urine output</td>
<td>Slightly decreased</td>
<td>Moderately increased</td>
<td>Very thirsty or too lethargic to indicate</td>
</tr>
<tr>
<td>Thirst</td>
<td>Slightly increased</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Adapted from Duggan et al.7 See text regarding hypernatremic dehydration. The percentages of body weight reduction that correspond to different degrees of dehydration will vary among authors. The critical factor in assessment is the determination of the patient’s hemodynamic and perfusion status. If a clinician is unsure of the category into which a patient falls, it is recommended that therapy for the more severe category be used.

† Bradycardia may appear in severe cases.
therapy, electrolyte levels should be measured and hydration may not be present. In children receiving bolus infusion of ORT solution can result in incorrect by the repeated administration of small volumes of a glucose-electrolyte solution frequently. Studies have indicated that therapy can be initiated with 5-mL (1-teaspoon) aliquots given every 1 to 2 minutes. Although this technique is labor intensive, it can be done by a parent and will deliver 150 to 300 mL/h.

As dehydration and electrolyte imbalance are corrected by the repeated administration of small amounts of the solution, vomiting often decreases in frequency. As the vomiting lessens, larger amounts of the solution can be given at longer intervals. When rehydration is achieved, other fluids, including milk, as well as food, may be introduced.

The use of a nasogastric tube is another option in a child with frequent vomiting; continuous rather than bolus infusion of ORT solution can result in improved absorption of fluid and electrolytes. Nasogastric infusion also can be used as a temporary expedient while IV access is being sought; however, nasogastric infusion should not be used in a comatose patient or in a child who may have ileus or an intestinal obstruction.

The committee did not evaluate the use of antiemetic drugs. Consensus opinion is that antiemetic drugs are not needed. Physicians who feel that antiemetic therapy is indicated in a given situation should be aware of potential adverse effects.

If vomiting continues despite efforts to administer an oral rehydrating solution, IV hydration is indicated, with return to the oral route when vomiting abates.

Refusal to Take an Oral Rehydrating Solution

Experience gained from more than 25 years of ORT use indicates that children who are dehydrated rarely refuse ORT; however, those who are not dehydrated may refuse the solution because of its salty taste. Children with mild diarrhea and no dehydration should be fed regular diets and do not require glucose-electrolyte solutions. As long as it is clear to the physician and parents that the child is not dehydrated and is in stable condition or showing improvement, special solutions need not be added to the regular feeding routine; however, young children should be given more fluids than usual during an episode of diarrhea.

Some practical techniques exist to induce reluctant children to drink glucose-electrolyte solutions. Administering the solution in small amounts at first may allow the child to get accustomed to the taste. Some commercial solutions have flavors added that do not alter their basic composition but may make them more palatable. Glucose-electrolyte solutions can be frozen into an ice-pop form, which may appeal to some children.

IV Therapy

Clinical studies strongly emphasize ORT; yet the clinician must know when and how to administer IV therapy, which maintains an important role in the treatment of children with diarrhea. All children who are severely dehydrated and in a state of shock or near shock require immediate and vigorous IV therapy. Children who are moderately dehydrated and who cannot retain oral liquids because of persistent vomiting also should receive fluids by the IV route, as should children who are unconscious or have ileus. Administration of ORT is labor intensive, requiring caregivers who can administer small amounts of fluid at frequent intervals. If such personnel are not available, IV therapy is indicated.

Clinicians must evaluate a child’s condition in light of the circumstances. If staff are skilled in IV administration and are unable to devote time to oral rehydration, and if reliable parents are not available, insertion of an IV line will be more expedient. Facility in IV therapy should not lead automatically to its use. Because children may show considerable improvement after periods of IV therapy, a child who is not severely dehydrated may be able to go home and complete rehydration orally, if proper follow-up is available, after receiving IV fluids for several hours in an emergency department or a similar facility.

The committee emphasizes the need for clinicians to recognize the advantages and disadvantages of both ORT and IV therapy in selecting the best treatment for an individual patient in a specific setting.

Costs

The major factor affecting the cost of rehydrating a child is the setting in which therapy occurs, with the expense increasing as one moves from home to office to emergency department or hospital ward. Oral rehydration is better suited to less-intensive levels of care, but clinicians must be certain that adequate assistance and supervision are available to provide effective therapy. If appropriate assistance is not available, a child may require hospital care for ORT. Clinicians should document the requirements of these patients to justify the need for such services to insurers.

Specific Therapy

The treatment of a child with diarrhea is directed primarily by the degree of dehydration present.
**No Dehydration**

ORT. Although ORT has been used to replace ongoing stool losses in children with mild diarrhea and no dehydratation by giving 10 mL/kg for each stool,7 these children are the least likely to take ORT, in part because of the salty taste of the solutions. If the stool output remains modest, a supplemental glucose-electrolyte solution may not be required if age-appropriate feeding is continued and fluid consumption is encouraged.

**Feeding.** Continued age-appropriate feeding, with the foods discussed above and increased fluid intake, may be the only therapy required if hydration is normal, which is the case in most US children with diarrhea. Infants should continue to drink human milk or regular strength formula. Older children may continue to drink milk.

**Mild Dehydration (3% to 5%)**

ORT. Dehydration should be corrected by giving 50 mL/kg ORT plus replacement of continuing losses during a 4-hour period.7 Replacement of continuing losses from stool and emesis is accomplished by giving 10 mL/kg for each stool; also, emesis volume is estimated and replaced. Reevaluation of hydration and replacement of losses should occur at least every 2 hours.

**Feeding.** As soon as dehydration is corrected, feeding should begin and should follow the guidelines given above.

**Moderate Dehydration (6% to 9%)**

ORT. Dehydration is corrected by giving 100 mL/kg ORT plus replacement of continuing losses during a 4-hour period. Rapid restoration of the circulating volume helps correct acidosis and improves tissue perfusion, which aids the early refeeding process. At the end of each hour of rehydration, hydration should be assessed, and continuing stool and emesis losses should be calculated with the total added to the amount remaining to be given. This task may be accomplished best in a supervised setting, such as an emergency department, urgent-care facility, or physician’s office.

**Feeding.** When rehydration is complete, feeding should be resumed and should follow the guidelines given above.

**Severe Dehydration (≥10%)**

Severe dehydration causes shock or a near-shock condition and is a medical emergency. The key to the treatment of the severely dehydrated child is bolus IV therapy with a solution such as normal saline or Ringer’s lactate. A common recommendation is to give 20 mL/kg of body weight during a 1-hour period; however, larger quantities and much shorter periods of administration may be required.

Electrolyte levels must be determined in children with severe dehydration. Frequent clinical reevaluation is critical. If the patient does not respond to rapid bolus rehydration, the clinician should consider the possibility of an underlying disorder, including, but not limited to, septic shock, toxic shock syndrome, myocarditis, myocardiopathy, or pericarditis.

For appropriate guidance in treating these critically ill patients, the reader is referred to comprehensive reviews.43-45

**ORT.** When the patient’s condition has stabilized and mental status is satisfactory, ORT may be instituted, with the IV line kept in place until it is certain that IV therapy is no longer needed.

**Feeding.** When rehydration is complete, feeding should be resumed and should follow the guidelines given above.

**THERAPY WITH ANTIDIARRHEAL COMPOUNDS**

Drugs are used to alter the course of diarrhea by decreasing stool water and electrolyte losses, shortening the course of illness, or relieving discomfort. Passage of a formed stool is not in itself a measure of successful therapy, because water can remain high in formed stools. Such cosmetic changes may give patients or their families a false sense of security, causing a delay in seeking more effective therapy.

A variety of pharmacologic agents have been used to treat diarrhea. These compounds may be classified by their mechanisms of action, which include: (1) alteration of intestinal motility, (2) alteration of secretion, (3) adsorption of toxins or fluid, and (4) alteration of intestinal microflora. Some agents may have more than one mechanism of action. Many of the agents have systemic toxic effects that are augmented in infants and children or in the presence of diarrheal disease; most are not approved for children younger than 2 or 3 years. Few published data are available to support the use of most antidiarrheal agents to treat acute diarrhea, especially in children. For the purposes of this review, these drugs have been grouped for analysis by their proposed mechanisms of action. Agents for which there are sufficient available data are considered individually. Table 4 lists generic and brand names of the drugs commonly used to treat persons with diarrhea.

**Recommendation.** As a general rule, pharmacologic agents should not be used to treat acute diarrhea. However, these agents may provide symptomatic relief if other measures are not successful or if the patient or the family requests medication for the symptoms of diarrhea. Even though these agents are not advocated in this review, they should be available for use in patients with acute diarrhea. The clinician should be familiar with the names, formulations, and dosages of these agents.

**TABLE 4. Medications Used to Relieve Symptoms in Patients With Acute Diarrhea**

<table>
<thead>
<tr>
<th>Mechanism of Action</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alteration of intestinal motility</td>
<td>Opiates (Loperamide, Imodium, Imodium-AD, Maalox Antidiarrhea, Pepto Diarrhea Control) Difenoxin and atropine (Motofen) Diphenoxylate and atropine (Lomotil) Tincture of opium (paregoric)</td>
</tr>
<tr>
<td>Alteration of secretion</td>
<td>Bismuth subsalicylate (Pepto-Bismol)</td>
</tr>
<tr>
<td>Adsorption of toxins or water</td>
<td>Attapulgite (Diasorb, Donnagel, Kapectate, Rheaban)</td>
</tr>
<tr>
<td>Alteration of intestinal microflora</td>
<td>Lactobacillus (Pro-Bionate, Superdophilus)</td>
</tr>
</tbody>
</table>

* The actual formulations marketed under these trade names change frequently. More changes are anticipated in the near future based on Food and Drug Administration rulings. Other medications with similar mechanisms of action may be available.

† Requires prescription.
diarrhea (based on limited studies and strong committee consensus).

Drugs That Alter Intestinal Motility

Loperamide

Loperamide is a piperadine derivative, chemically related to meperidine, which decreases transit velocity and may increase the ability of the gut to retain fluid. Loperamide also may inhibit calmodulin, a protein involved in intestinal transport. Loperamide is more specific for the μ-opiate receptors of the gut and thus has fewer of the effects on the central nervous system associated with other opiates. Under certain controlled conditions, it also has been shown to have antisecretory properties, but this effect was not seen in an adult volunteer model of acute gastroenteritis. Well-designed clinical trials in both adults and children have demonstrated some beneficial effects of loperamide in the treatment of acute diarrhea. Loperamide, when used in conjunction with oral rehydration, reduced the volume of stool losses and shortened the course of disease in children 3 months to 3 years of age. These effects, although statistically significant, were not clinically significant, and the small number of studies makes it difficult to combine them in a meaningful way. In addition, many of the studies and case reports involving children have shown unacceptably high rates of side effects, including lethargy, ileus, respiratory depression, and coma, especially in infants. Death also has been associated with loperamide therapy.

Recommendation. Loperamide is not recommended to treat acute diarrhea in children (based on limited scientific evidence that the risks of adverse effects of loperamide outweigh its limited benefits in reducing stool frequency, and on strong committee consensus).

Other Opiates

Few data support the use of other opiate analogues or opiate and atropine combinations (Table 4) to treat diarrhea in children. The potential for toxic side effects is a major concern. Opiates can produce respiratory depression, altered mental status, and ileus. These drugs pose an additional danger to individuals with fever, toxemia, or bloody stools, because they have been shown to worsen the course of diarrhea in patients with shigellosis, antimicrobial-associated colitis, and diarrhea caused by Escherichia coli 0157:H7.

Recommendation. Opiates as well as opiate and atropine combination drugs are contraindicated in the treatment of acute diarrhea in children (based on limited scientific evidence and strong committee consensus).

Anticholinergic Agents

Parasympatholytic agents have been used in the treatment of acute gastroenteritis to decrease the cramping associated with diarrhea. They exert their effect on gastrointestinal tract smooth muscle by decreasing motility and reducing tone. Few data are available to document the efficacy of these agents in children with diarrhea. A placebo-controlled trial of the drug mepenzolate bromide in adults failed to demonstrate a positive effect, and many anticholinergic side effects were reported. A dry mouth, the most frequently observed side effect, may alter the clinical evaluation of dehydration. Infants and young children are especially susceptible to the toxic effects of anticholinergic drugs. Coma, respiratory depression, and paradoxical hyperexcitability have been reported.

Recommendation. Anticholinergic agents are not recommended in the management of diarrhea in children (based on limited scientific evidence and strong committee consensus).

Alteration of Secretion

Bismuth Subsalicylate

Bismuth subsalicylate, as well as bismuth subnitrate and bismuth subgallate, has been used as an adjunctive therapy for acute diarrhea. The mechanism of action of these compounds is uncertain, although laboratory studies have shown that bismuth subsalicylate inhibits intestinal secretion caused by enterotoxigenic E coli and cholera toxins. Controlled trials have demonstrated that bismuth subsalicylate reduced the frequency of unformed stools and increased stool consistency in adults with traveler's diarrhea and in volunteers receiving the Norwalk virus. A controlled clinical trial in children with acute diarrhea demonstrated that the administration of bismuth subsalicylate was associated with a decreased duration of diarrhea and a decreased frequency of unformed stools. A second controlled trial in children receiving only oral therapy for acute diarrhea found that bismuth subsalicylate administration was associated with a shorter duration of diarrhea, decreased total stool output, decreased need for intake of an oral rehydration solution, and reduced hospitalization, although criteria for hospital discharge were not standardized in this study. Overall, the beneficial effects have been modest, and the treatment regimen involves a dose every 4 hours for 5 days. Salicylate absorption after ingestion of a bismuth subsalicylate compound has been reported in adults and children. Insufficient data exist as to the risk of Reye syndrome associated with this compound; such a risk is of at least theoretical concern. Bismuth-associated encephalopathy and other toxic effects have been reported after the long-term ingestion of high doses of bismuth-containing compounds.

Recommendation. The routine use of bismuth subsalicylate is not recommended in the treatment of children with acute diarrhea (based on limited scientific evidence that the benefit of bismuth subsalicylate is modest in most children with diarrhea because of concerns about toxic effects, and on committee consensus; further studies may demonstrate a therapeutic role for this agent).
Adsorption of Fluid and Toxins

Adsorbents

Several antidiarrheal compounds are reported to work by adsorbing bacterial toxins and by binding water to reduce the number of bowel movements and to improve stool consistency. Kaolin-pectin, fiber, and activated charcoal are classified in this category, but the only such agent currently used widely is attapulgite. No conclusive evidence is available to show that these agents reduce the duration of diarrhea, stool frequency, or stool fluid losses. Disadvantages include adsorption of nutrients, enzymes, and antibiotics in the intestine.

Recommendation. Adsorbents are not recommended for the treatment of diarrhea in children (based on limited scientific evidence and committee consensus; efficacy has not been shown, although major toxic effects are not a concern).

Alteration of Intestinal Microflora

Lactobacillus

Lactobacillus is administered to patients with acute diarrhea to alter the composition of the intestinal flora. Normally, saccharolytic bacteria in the intestine ferment dietary carbohydrates that have not been absorbed completely, causing a decrease in pH that produces short-chain fatty acids and deverts intestinal pathogens. The short-chain fatty acids are absorbed through the colonic mucosa and facilitate absorption of water. When a patient has diarrhea, the fecal flora are diminished, production of short-chain fatty acids is reduced, and colonic absorption of water is impaired. There is no consistent evidence that administration of Lactobacillus-containing compounds alters the course of diarrhea. The supplementation of infant formula with Bifidobacterium bifidum and Streptococcus thermophilus has been shown to reduce the incidence of acute diarrhea and rotavirus shedding in hospitalized infants. Two studies of young children demonstrated a reduction in the duration of diarrhea caused by rotavirus associated with the administration of Lactobacillus GG. Additional research is needed in the area of bacterial interference using Lactobacillus-containing compounds.

Recommendation. Lactobacillus-containing compounds currently are not recommended in the treatment of acute diarrhea in children (based on limited scientific evidence and committee consensus; efficacy has not been shown, although toxic effects are not a concern).

Newer Treatments for Diarrhea

Several medications have shown promise in the treatment of acute diarrhea on an experimental basis, mostly in studies involving adults. These include derivatives of berberine, nicotinic acid, clonidine, chloride channel blockers, calmodulin inhibitors, octreotide acetate, and nonsteroidal antiinflammatory drugs. All of these agents must be considered experimental at this time.

Other Agents

A variety of drugs not discussed herein are used in clinical practice to treat diarrhea. Little evidence exists regarding their safety or efficacy; therefore, they cannot be recommended.

RESEARCH ISSUES

In developing this practice parameter, the committee reviewed a large body of literature, but only a fraction was amenable to rigorous scientific analysis. Only the issue of refeeding was supported by a sufficient number of comparable studies to allow meta-analysis. The systematic evaluation of the evidence for the remaining questions points to areas that need more research.

The practice parameter, "The Management of Acute Gastroenteritis in Young Children," was reviewed by the appropriate committees and sections of the AAP, including the Chapter Review Group, a focus group of office-based pediatricians representing each AAP district: Gene R. Adams, MD; Robert M. Corwin, MD; Lawrence C. Pakula, MD; Barbara M. Harley, MD; Howard B. Weinblatt, MD; Thomas J. Herr, MD; Kenneth E. Matthews, MD; Diane Fuquay, MD; Robert D. Mines, MD; and Delosa A. Young, MD. Comments also were solicited from relevant outside medical organizations. The clinical algorithm was developed by James R. Cooley, MD, Harvard Community Health Plan.

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GENERAL REFERENCES


ALGORITHM

1. Clinician takes history and examines patient, aged 1 month to 5 years, with acute diarrhea.

2. (1) Clinician obtains patient's current weight. OR (2) Clinician estimates % dehydration, if no recent weight for comparison is available. (A)

3. Is one or more of the following present?: (1) Patient < 10% dehydrated (A); OR (2) Signs of shock; OR (3) Patient unconscious; OR (4) Ileus present.

4. Yes → (1) Hospitalize patient. (2) Give intravenous fluid therapy with bolus of normal saline or Ringer's lactate, 20-40 mL/kg for 1 hour. Reevaluate and repeat if necessary. (3) Begin oral rehydration when patient is stable, as per Box 6. (B)

5. No → Is patient 6-9% dehydrated by weight loss and/or clinical estimation? (A)

6. Yes → Begin oral rehydration therapy at 100 mL/kg over a 4 hour period, plus replacement of ongoing losses. (C)

7. No → Is patient 3-5% dehydrated by weight loss or clinical estimation? (A)

8. Yes → Begin oral rehydration therapy at 50 mL/kg over a 4 hour period, plus replacement of ongoing losses. (C)

9. No → Is patient tolerating oral rehydration therapy? (D)

10. Yes → Continue oral rehydration for 4-6 hours or until rehydrated. (E)

11. No → Patient with diarrhea is less than 3% dehydrated by weight loss or clinical estimation. (F)

12. (1) Institute intravenous therapy. (2) Consider nasogastric tube.

13. (1) Continue child's regular diet. (2) Consider added glucose-electrolyte solution to replace stool losses, or give more usual dietary fluids. (G)

14. (1) Resume breast feeding, formula or milk. (2) Resume recommended foods. (3) Replace ongoing losses with glucose-electrolyte solution. (H)
Annotations for the Management of Acute Gastroenteritis in Young Children

Rehydration and Refeeding Algorithm

A. See Table 3 for guidance in the assessment of the degree of dehydration.

B. Restoration of cardiovascular stability is critical and is accomplished by giving bolus IV therapy with normal saline or Ringer's lactate solution (see text). In the patient who does not respond, consider the possibility of an underlying disorder, such as myocarditis, myocardiopathy, pericarditis, septic shock, or toxic shock syndrome. When the patient is in stable condition and has achieved satisfactory mental status, ORT can be used according to the ORT guidelines.

C. Solutions containing 45 to 90 mmol/L sodium should be given in a volume of 100 mL/kg for moderate dehydration and 50 mL/kg for mild dehydration. Giving the child these volumes requires patience and persistence, and progress must be monitored frequently.

D. Intractable, severe vomiting, unconsciousness, and ileus are contraindications to ORT. Persistent refusal to drink may require a trial of IV therapy.

E. The rehydration phase usually can be completed in 4 hours; reevaluation should occur every 1 to 2 hours. See text for guidance to decide when rehydration has been achieved.

F. The type and intensity of therapy will vary with the individual clinical situation.

G. Often, a child has diarrhea but remains adequately hydrated. The parent can be reassured but should be taught to assess hydration and to identify a worsening condition. If the stool output remains modest, ORT might not be required if early, age-appropriate feeding is instituted and increased consumption of usual dietary fluids is encouraged. More significant stool losses can be replaced with an oral rehydrating solution at the rate of 10 mL/kg for each stool.

H. Breastfeeding should be resumed. Nonlactose formula, milk-based formula, or milk may be given, although a small percentage of children will not tolerate lactose-containing fluids. Lactose-containing solutions seem to be tolerated better when combined with complex carbohydrates in weaned children. Children who are eating foods may resume eating, although certain foods are tolerated better than others. Recommended foods include complex carbohydrates (rice, wheat, potatoes, bread, and cereals), lean meats, yogurt, fruits, and vegetables. Avoid fatty foods and foods high in simple sugars (including juices and soft drinks). Supplement feeding with an oral electrolyte solution, 10 mL/kg for each diarrheal stool and the estimated amount vomited for each emesis.
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