Diarrhoea and/or Vomiting (Gastroenteritis) Pathway
Clinical Assessment / Management for Children with suspected Gastroenteritis

Management - Primary Care and Community Settings

**SUSPECTED GASTROENTERITIS**

<table>
<thead>
<tr>
<th>History Assessment of Vital Signs - Temp, Heart Rate, RR, capillary refill time</th>
<th>Consider differential diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk factors for dehydration - see figure 1</td>
<td></td>
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</tbody>
</table>

**Consider alternative diagnoses to gastroenteritis if:**
- Fever (>38) • Shortness of breath • Altered consciousness • Signs of meningism • Blood in stool • Bilious (green) vomit
- Vomiting alone • Recent head injury • Recent burn • Severe localised abdominal pain • Abdominal distension or rebound tenderness
- Consider diabetes

**Do the symptoms and/or signs suggest an immediately life threatening (high risk) illness?**
- Yes
  - Refer immediately by emergency ambulance
    - Alert Paediatrician
    - Stay with child whilst waiting and prepare documentation
  - Discuss with Paediatrician

**No**

**Do the symptoms and/or signs suggest an immediately life threatening (high risk) illness?**
- Yes
  - Refer immediately by emergency ambulance
    - Alert Paediatrician
    - Stay with child whilst waiting and prepare documentation
  - Discuss with Paediatrician

**No**

**Clinical Assessment / Management for Children with suspected Gastroenteritis**

<table>
<thead>
<tr>
<th>Table 1 Clinical Findings</th>
<th>Green - low risk</th>
<th>Amber - intermediate risk</th>
<th>Red - high risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Over 3 months old</td>
<td>Under 3 months old</td>
<td></td>
</tr>
<tr>
<td>Behaviour</td>
<td>• Responds normally to social cues • Content / smiles • Stays awake / awakens quickly • Strong normal crying / not crying • Appears well</td>
<td>• Altered response to social cues • No smile • Decreased activity • Irritable • Lethargic</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>• Normal skin colour • Warm extremities</td>
<td>• Normal skin colour • Warm extremities</td>
<td>• No response to social cues</td>
</tr>
<tr>
<td>Hydration</td>
<td>• CRt &lt; 2 secs • Moist mucous membranes • Fontanelle normal</td>
<td>• CRt 2-3 secs • Dry mucous membranes • Sunkent fontanelle</td>
<td>• No response to social cues</td>
</tr>
<tr>
<td>Urine output</td>
<td>• Normal urine output</td>
<td>• Reduced urine output / no urine output for 12 hours</td>
<td>• No urine output for &gt;24 hours</td>
</tr>
<tr>
<td>Respiratory</td>
<td>• Normal breathing pattern and rate*</td>
<td>• Normal breathing pattern and rate*</td>
<td>• Abnormal breathing / tachypnoea*</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>• Heart rate normal • Peripherial pulses normal</td>
<td>• Mild tachycardia* • Peripherial pulses normal</td>
<td>• Severe tachycardia** • Weak peripheral pulses</td>
</tr>
<tr>
<td>Eyes</td>
<td>• Not sunken</td>
<td>• Sunken Eyes</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *Normal paediatric values (APLS):* (APLS®)
- Respiratory Rate at rest: [b/min]  
  - < 1 year: 30 - 40  
  - 1-2 years: 25 - 35  
  - 2-5 years: 25 - 30  
  - 5-12 years: 20-25  
  - > 12 years: 15-20  
- Heart Rate [bpm]:  
  - < 1 year: 110 - 160  
  - 1-2 years: 100 - 150  
  - 2-5 years: 95 - 140  
  - 5-12 years: 80-120  
  - > 12 years: 60-100

**Fig 1** Children at increased risk of dehydration are those:
- • Aged < 1 year (and especially the < 6 month age group) • Have not taken or have not been able to tolerate fluids before presentation • Have vomited three times or more in the last 24 hours • Has had six or more episodes of diarrhoea in the past 24 hours • History of faltering growth

**Fig 2** Management of Clinical Dehydration
- Fluid trial – Dilute apple juice/ORS 5ml every 5 mins
- Consider Ondansetron 0.1mg/kg PO/sublingual (max 4mg) if continued vomiting in context of suspected gastroenteritis
- If fluids not tolerated or hydration not improved within 2 hours please refer to paediatric team
- If fluids tolerated and hydration improves proceed to green action with consideration of referral to acute paediatric community nursing team if available

**Green Action**
- Provide Written and Verbal advice (see patient advice sheet)
- Continue with breast and / or bottle feeding
- Encourage fluid intake, little and often eg. 5mls every 5 mins
- Children at increased risk of dehydration (see Fig 1)
- Confirm they are comfortable with the decisions / advice given.

**Amber Action**
- Begin management of clinical dehydration algorithm [see Fig 2]
- Agree a management plan with parents +/- seek advice from paediatrician
- Consider referral to acute paediatric community nursing team if available
- Check blood glucose

**Urgent Action**
- Refer immediately to emergency care - consider emergency ambulance
- Alert Paediatrician
- Consider initiating Management of Clinical Dehydration [Fig 2] awaiting transfer
- Consider commencing high flow oxygen support.