

Diarrhea*	
<b>PowerPlans</b>	GI Chronic Diarrhea Labs Plan, SSYCE Plan, Stool Studies plan
<b>Differential</b>	<ul style="list-style-type: none"> <li>• <b>Acute:</b> Gastroenteritis (viral or bacterial), food poisoning, antibiotic-associated, toxic ingestion, hyperthyroidism, disaccharidase deficiency (infants)</li> <li>• <b>Chronic:</b> Postinfectious lactase deficiency, IBS/IBD, Celiac, milk protein allergy (infants), lactose intolerance, laxative abuse, giardiasis, secretory tumor, lymphangiectasia, familial villous atrophy</li> </ul>
<b>Workup</b>	<ul style="list-style-type: none"> <li>• Consider FOBT, ESR/CRP, fecal calprotectin or lactoferrin, infectious stool studies (SSYCE esp. If febrile, bloody stools, immunocomp.), C. diff, stool for O&amp;P, viral antigens including rotavirus), fecal elastase, fecal reducing substances</li> <li>• To differentiate osmotic vs. secretory diarrhea:</li> <li>• Stool Osmolar Gap = Stool Osm - (2 x [stool Na + stool K]) <ul style="list-style-type: none"> <li>■ <b>Osmotic Diarrhea (osmolar gap &gt; 100):</b> Maldigested nutrients draw water into the intestinal lumen (e.g., celiac, pancreatic disease, lactose intolerance). Stool volume <b>decreased with fasting</b>.</li> <li>■ <b>Secretory Diarrhea (osmolar gap &lt; 100 mOsm/kg):</b> Secretion of water into intestine exceeds absorption (e.g., cholera, hyperthyroidism, nonosmotic laxative use). Large volumes, <b>does not decrease with fasting</b>.</li> </ul> </li> </ul>
<b>Management</b>	<ul style="list-style-type: none"> <li>• Hydration</li> <li>• Generally avoid anti-diarrheals</li> </ul>

GER/GERD*															
<b>PowerPlans</b>	GI AMB Gastroesophageal Reflux Plan														
<b>Presentation</b>	<ul style="list-style-type: none"> <li>• <b>GER:</b> Reflux of gastric contents through LES into esophagus. <b>Normal</b> in infants. LES tone improves by 6m</li> <li>• <b>GERD</b> = GER + “troublesome symptoms” (back arching/Sandifer syndrome, <b>excessive crying</b> (&gt;3h/day), <b>feeding difficulties</b>, <b>slow weight gain</b>, <b>parental concern</b>)</li> </ul>														
<b>Treatment</b>	<table border="1"> <tr> <th colspan="2">Approach to GERD in the older child (JPGN 2018;66: 516-554)</th></tr> <tr> <td colspan="2"> <ul style="list-style-type: none"> <li>• H&amp;P, diet and lifestyle changes and if no improvement, brief trial of acid suppression with H2RA or PPI (4-8 weeks only)</li> <li>• Consider GI referral if no improvement on PPI or if unable to wean → upper endoscopy +/- pH impedance testing</li> </ul> </td></tr> <tr> <th colspan="2">Approach to infant GERD (JPGN 2018;66: 516-554)</th></tr> <tr> <td>1</td><td><b>Reflux precautions:</b> Elevate the head of the bed, avoiding overfeeding, keep infants upright after feeds, thicken feeds (Similac SpitUp/Enfamil AR, or with rice/oatmeal cereal [1 teaspoon of cereal per ounce of formula])</td></tr> <tr> <td>2</td><td>2-4w trial of <b>hydrolyzed or amino acid formula</b> or eliminate cow's milk in maternal diet if BFing</td></tr> <tr> <td>3</td><td>Consider GI referral <b>4w</b> trial of <b>Ranitidine or PPI</b> (limited evidence of efficacy; ↑ risk of CAP PNA, GI infections, vitamin deficiencies and fractures)</td></tr> <tr> <td>Refractory</td><td>Referral to GI (will consider Nissen fundoplication)</td></tr> </table>	Approach to GERD in the older child (JPGN 2018;66: 516-554)		<ul style="list-style-type: none"> <li>• H&amp;P, diet and lifestyle changes and if no improvement, brief trial of acid suppression with H2RA or PPI (4-8 weeks only)</li> <li>• Consider GI referral if no improvement on PPI or if unable to wean → upper endoscopy +/- pH impedance testing</li> </ul>		Approach to infant GERD (JPGN 2018;66: 516-554)		1	<b>Reflux precautions:</b> Elevate the head of the bed, avoiding overfeeding, keep infants upright after feeds, thicken feeds (Similac SpitUp/Enfamil AR, or with rice/oatmeal cereal [1 teaspoon of cereal per ounce of formula])	2	2-4w trial of <b>hydrolyzed or amino acid formula</b> or eliminate cow's milk in maternal diet if BFing	3	Consider GI referral <b>4w</b> trial of <b>Ranitidine or PPI</b> (limited evidence of efficacy; ↑ risk of CAP PNA, GI infections, vitamin deficiencies and fractures)	Refractory	Referral to GI (will consider Nissen fundoplication)
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Inflammatory Bowel Disease*	
<b>PowerPlan</b>	GI Inflammatory Bowel Disease Admit Orderset/Workup Plan/Medications Plan