THE PEDIATRICS FOR EMERGENCY PHYSICIANS NETWORK

Pediatric GI

Diagnosis	Usual Age of Onset	Hallmarks/Presentation
Colic	**3 wks – 3 mo**	**Crying/ fussy alot, but completely consolable**
Pyloric Stenosis	**Peak: 3 wks (0-5 mo)**	**Postprandial vomiting of milk only (no bile)** **Not always projectile**
Overfeeding	**Same age as pyloric stenosis**	**Postprandial vomiting of milk only** **Dx made by hx: determine wt for age & wt gain since birth, and check feeding hx for recent increase in volume, and compare amt of feeds with baby's normal nutritional requirement:** *** infant nutritional requirement=100kcal/kg (formula: 20kcal/oz)**
GERD	**Same age as pyloric stenosis**	**Postprandial vomiting of milk only.** **H/o arching back during or after feeds ("Sandifer's")** **H/o being uncomfortable/fussy during or after feeds** *** In a well baby, if overfeeding & pyloric stenosis are ruled out, then GERD is most likely diagnosis**
Volvulus	**0 – 3 months**	**Any bilious vomiting (i.e-pure yellow or any green)**
Intussusception	**3 mo – 3 yo* (*may occur up to 4 yo)**	**May present 7 different ways:** **1) intermittent pain or crying (with or w/o bending knees to chest) 2) constant (inconsolable) crying** **3) unexplained lethargy** **4) bilious vomiting (green)** **5) hematochezia** **6) severe vomiting** **7) severe abdominal pain**
Hirschsprungs	**0 – 3 months**	**Classic hx: no stool first 24 hrs of life (not always)** **h/o severe constipation and/or abdominal distension**
Vomiting	**Infants**	**Always determine:** **? bilious or abdominal pain (volvulus, intussusception)** **? projectile (pyloric stenosis)** **? age< 2 months (? UTI)** **? arching back or fussy during/after feeds (GERD)** **? tachypnea or floppy or FTT (? CAH or metabolic disease)**
	Older children	**? abdominal pain or tenderness (appendicitis)** **? h/o persistent unexplained vomiting for weeks (even if no h/o headache) – consider head CT to rule out brain tumor**

I. Typical Scenarios

1. A 25day old otherwise healthy baby with vomiting (**milk only**) after feeds. Otherwise well. Normal vitals & exam.

   Diff Dx: **Overfeeding**
   GERD
   Pyloric stenosis
   UTI
   Metabolic disease (less common)

   Clinical approach: Determine from **birth weight + rate of weight gain + feeding history** whether **overfeeding** is the likely diagnosis – if overfeeding is not suggested by the history, then **check urine** for UTI & consider **US to r/o pyloric stenosis**. If both these tests are negative, most likely diagnosis is **GERD**.

   Lab testing: Always keep the less common possibility of metabolic disease (i.e. CAH & inborn-errors-of-metabolism) in the back of your mind, especially if any of the following: **poor weight gain**, **floppy tone**, **significant vomiting**. Also, since these young babies may be more dehydrated than they appear to be, you should have a low threshold for lab screening (ie chem.-7, VBG) which will help rule-out metabolic diseases, pyloric stenosis, & dehydration.

2. A 15 day old female with unremarkable perinatal and past medical history, vomited once 6 hours ago. Mother stated the vomit contained only milk, but when you probe further on your feeding history she says there were tiny **specks of green** in mostly milk. The baby is otherwise acting well now, as fed well three times since then, and on exam has normal vitals and a completely normal exam.

   Diff Dx: **Volvulus**
   Intussusception (Atypical at such a young age)

   Clinical approach: The patient needs a **stat UGI series** to rule out **volvulus**. If that test is negative, then **intussusception** should be ruled out. **Any green (or pure yellow) vomit---even only a single episode--- is bile.** Never be falsely reassured by the history of only a single episode with no further recurrence and/or a completely normal exam.

3. A 2 year old boy presents with sudden onset lethargy 3 hours ago, no h/o fever or URI, trauma, vomiting, diarrhea, abdominal pain. On exam, he is slightly pale, afebrile, normal vitals. He is arousable and interacts slightly but **goes back to** sleep.Mother is sole caregiver, no suspected trauma or infections.Abdomen soft, nontender. D-stick:100

Diff Dx: **Intussusception**
Encephalitis
Sepsis
Occult head trauma / child abuse
Ingestions/Toxic exposure

Clinical approach: This is a **common presentation for intussusception** *. While the entire differential diagnosis of altered mental status must be entertained, there is no preceding history of fever or illness, vitals are stable, no toxic exposure or trauma are suggested by history or exam. Rectal exam demonstrated bloody heme positive stool, and stat obstructive series x-rays were positive for intussusception, which was reduced by air enema. (Air enema is successful in 85% of cases).

* **Remember the 7 different ways intussuception may present (see chart, Section I above) and always consider the diagnosis early-on!**