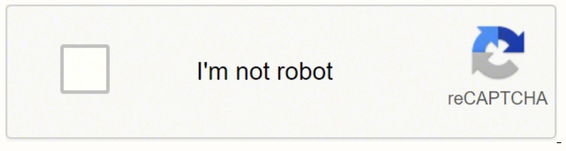

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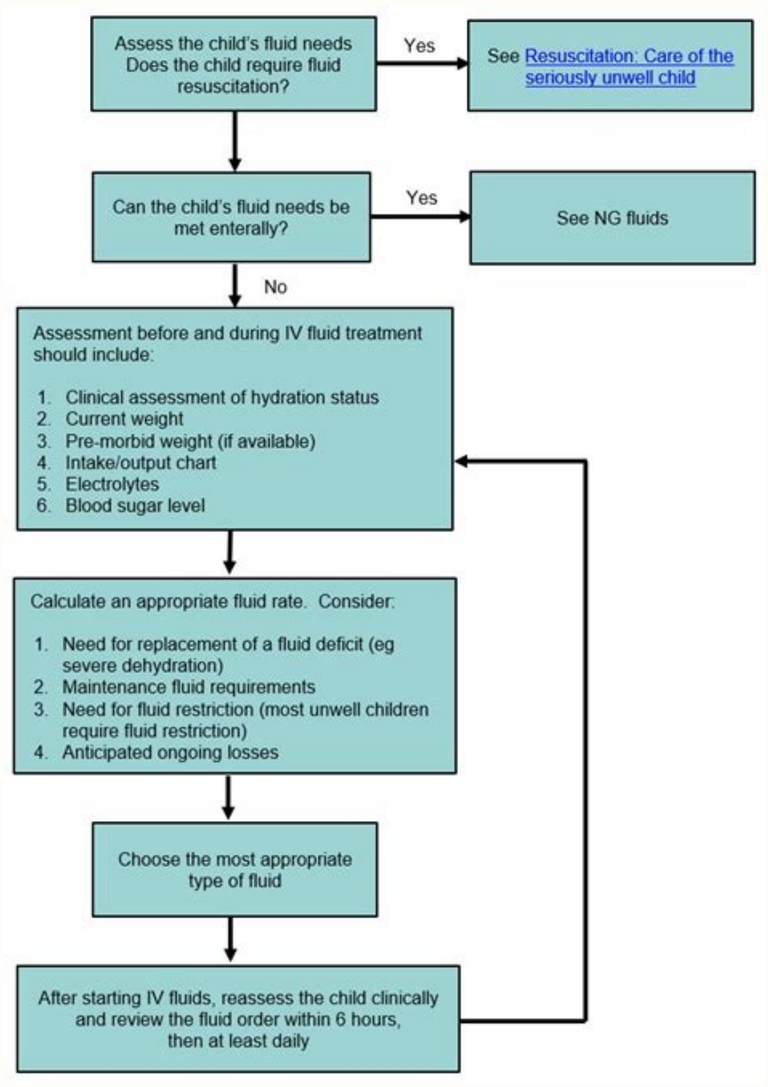

Summary of the included randomized controlled trials.

Study (N)	Route	Control	Alternative Route Rate	Outcome
Gremse (24)	NG	IV	Estimated fluid deficit during 6 h	Shorter hospitalizations, earlier formula intake with NG
Hidayat et al (75)	NG	IV	WHO standard ORS therapy	No outcome differences
Nager and Wang (90)	NG	IV	50 mL/kg Pedialyte during 3 h	IV insertion failure rate was higher than NG failure rate; no therapeutic outcome differences
Varavithya et al (22)	NG	IV	10–20 mL/kg during 2 h, followed by 130 mL/kg during 22 h	No outcome differences
Banerjee et al (60)	IO	IV	20–30 mL/kg bolus	IO placement was faster; no therapeutic outcome differences

NG, Nasogastric; *IV*, intravenous; *WHO*, World Health Organization; *ORS*, oral rehydrating solution; *IO*, intraosseous.

Clinical practice guidelines maintenance intravenous fluids in children. pediatrics.

If hypoglycemia is present, it should be appropriately corrected.Hyponatremia, hypernatremia, and hypoglycemia may occur in children with dehydration as a result of illness or complication of fluid replacement therapy. The measurement of electrolytes to determine the co-derangement of sodium is a notable exception. Hyponatremia may occur due to the administration of hypotonic solutions. This may require adjustment of water or sodium replacement. 2004 Jun 09;291(22):2746-54. MMWR Recomm Rep. crystalloids. It is not appropriate in children with severe dehydration and shock. Other contraindications include:Circulatory instability or shockAltered mental status (risk of aspiration)Persistent vomitingBloody diarrheaAcute abdomen, intestinal obstruction or paralytic ileusElectrolyte abnormalities such as hyponatremiaSignificant underlying illnessSevere respiratory distressIn a dehydrated child, there are many ways of enteral hydration and different solutions when intravenous fluid replacement is needed.Alternate forms of enteral hydration Normal plasma sodium rates are 135 to 144 mEq/L.Normal saline has plasma sodium of 154 mEq/L and 1/2 and 1/4 normal saline are a fraction of 154 mEq/L.Lactated Ringer's has a sodium concentration of 131 mEq/L.The three steps in treating dehydration are as follows:Correction of fluid deficit; this includes fluid lossMaintenance therapy; this involves physiologic requirements of fluid and electrolytesSustained replacement of continuing fluid lossesIt is as effective as intravenous fluid in replacing fluid and electrolyte losses and has many advantages. 2014 Jul;165(1):163-169.e2. It is difficult to accurately distinguish varying degrees of dehydration based on clinical examination alone. Intravenous maintenance fluid therapy in children. BUN shows partial linear relation to the degree of dehydration, but overall is non-specific.[4] The most useful lab test to determine the degree of dehydration is bicarb less than 17 mEq/L.[4]Children vary in required fluid intake due to increased metabolic rates, which cause increased fluid loss.[5] Tonicity applies to the concentration of carbohydrates and electrolytes. The implementation of an evidence-based algorithm based on the clinical dehydration score can decrease the frequency of intravenous fluid administration and reduce emergency room length of stay.An isotonic solution should be administrated for the correction of volume depletion, regardless of the plasma sodium concentration. Oral rehydration of infants in a large urban U.S. medical center. Initially, near age-appropriate vital signs may be present despite ongoing fluid losses. A prospective study of the usefulness of clinical and laboratory parameters for predicting percentage of dehydration in children. Water is essential for cellular homeostasis. Emerg Med Clin North Am. 2018 May;36(2):259-273. It is controlled by the release of antidiuretic hormone (ADH) from the posterior pituitary causing water retention, and by thirst mechanism.An isotonic solution does not change the volume of a cell. [PubMed: 12483054]17.Greenough A, Emery E, Hird MF, Gamsu HR. 2002 Dec;30(12):2649-54. A single 20-mL/kg bolus improves circulation but cannot normalize the hemodynamic status. This may be more relevant in infants and young children, especially if there is vomiting associated with diarrhea. Therefore, diagnosing dehydration requires a high index of suspicion.The monitoring of children with hypovolemia is a team approach. [PubMed: 9220501]5.Feld LG, Neuspiel DR, Foster BA, Leu MG, Garber MD, Austin K, Basu RK, Conway EE, Fehr JJ, Hawkins C, Kaplan RL, Rowe EV, Waseem M, Moritz ML., SUBCOMMITTEE ON FLUID AND ELECTROLYTE THERAPY. Two-thirds of the total body water (TBW) is intracellular. The recommended rates are the following: 100 ml/kg for the initial 10 kilograms of weight, 50 ml/kg for each kg between 10-20 kg, 20 ml/kg for each additional kg.[11] TonicityHistorically hypotonic IV fluids have been administered; however, several cases of morbidity and mortality were reported.[5][12][13][14] In most hospitalized children who developed hyponatremia, it was related to the administration of hypotonic fluid. The intestinal solute transport mechanisms develop the osmotic gradients due to the movement of electrolytes and nutrients through the cell. However, in disease states, these mechanisms may be overwhelmed. [PubMed: 28814256]14.McNab S, Ware RS, Neville KA, Choong K, Coulthard MG, Duke T, Davidson A, Dorofaeff T. This causes vomiting, diarrhea, or reduced oral fluid intake and is, therefore, can develop dehydration.This causes extracellular fluid depletion through either diarrhea or vomiting. Albumin versus crystalloid prime solution for cardiopulmonary bypass in young children. The TBW varies with age; 70% in infants, 65% in children, and 60% in adults. A fluid requirement of more than 60 ml/kg without improvement in clinical status indicates other causes such as septic shock or hemorrhage.The fluid administration rate is determined by maintenance requirements, estimated fluid deficit, and ongoing fluid losses. Early and appropriate fluid administration improves outcomes and reduces mortality in children. Hyperosmolar solutions, those with excessive carbohydrates, can also cause osmotic diarrhea, which worsens fluid loss. An overly fluid administration can cause clinically significant over-hydration. Children maintain cardiac output by raising their heart rate. Acad Emerg Med. [PubMed: 15187057]4.Vega RM, Avner JR. In such situations, an IV fluid administration may be more efficient for rehydration. [PubMed: 4009330]7.Bellemare S, Hartling L, Wiebe N, Russell K, Craig WR, McConnell D, Klassen TP. Oral versus intravenous rehydration of moderately dehydrated children: a randomized, controlled trial. 2005 Feb;115(2):295-301. J Pediatr. J Paediatr Child Health. Oral fluid replacement is preferred in children in mild to moderate dehydration unless any contraindication exists. 2016 Feb;52(2):137-40. In such a situation, the degree of dehydration may be underestimated; fluid shifts from the intracellular to the extracellular compartments. Frequent and periodic re-evaluation should be performed to ensure appropriate fluid volume is being administered. This includes body weight and fluid input and output. Children with respiratory distress should also receive IV fluids.[5]Oral rehydration is a preferred method of fluid administration in mild to moderate dehydration in the absence of any contraindication. The passive movement of water follows this. Objectives: Describe the indications of fluids administration in children with dehydration.Review the treatment considerations for oral hydration in children.Review the treatment considerations for IV hydration in children.Outline the importance of collaboration and communication among the interprofessional team to improve outcomes for patients receiving treatment for hypovolemia. 2018 Aug 03;8:CD000567. The ability to correctly identify dehydration has important clinical implications. . 1993 Feb;152(2):157-9. However, severe dehydration presents with early signs of hypovolemic shock. 1997 Jun;13(3):179-82. These studies

showed decreased edema, negative fluid balance, and less weight gain; however, no difference in length of intensive care unit stay, ventilation days, or mortality noted.[16][17] Dextrose In children, who are not taking adequate calories orally, 5% dextrose (D5) should be added to maintenance fluids. Isotonic versus hypotonic solutions for maintenance intravenous fluid administration in children. For example, infants and young children with mild dehydration may present with either minimal or no clinical findings other than reduced urine output. There is a total body sodium deficiency despite elevated sodium concentrations. Oral rehydration is a safe and cost-effective method for the management of children with dehydration. Eur J Pediatr. It is caused by a deficit of sodium or an excess of free water. Also, children with moderate dehydration manifest with dry mucous membranes, decreased skin turgor, tachycardia with a prolonged capillary refill, and abnormal respiratory pattern.Treatment recommendations are based on the assessment of dehydration severity.[2] Vital signs and physical exam should be frequently monitored to guide and assess the severity of dehydration. There are two major fluid compartments: the intracellular fluid (ICF) and the extracellular fluid (ECF). Pediatr Emerg Care. [PMC free article: PMC3058669] [PubMed: 21040104]2.Santillanes G, Rose E. Appropriate and timely fluid administration is vital for an optimal outcome. Pediatrics. 2003 Nov 21;52(RR-16):1-16. The amount of fluid deficit should depend upon the change in weight (if available) or clinical signs.The recommended rate is 50 mL to 100 mL/kg over 2 to 4 hours for oral fluids.[10] It is recommended to use an oral rehydration solution rather than free water or commercial sports drink.[10] Nasogastric administration is another route for rehydration with similar rates and fluids recommended for oral administration. In hospitalized children, there is an excessive release of ADH. BMC Med. However, oral rehydration therapy has been underused.[7] A Cochrane review reports only 4% had true indication in children who received intravenous hydration.[2] Research demonstrates ORT is as effective as intravenous hydration in children with moderate dehydration.[8] A meta-analysis showed no clinically significant difference when oral rehydration was compared with intravenous rehydration in terms of safety and efficacy.[7]The administration of intravenous fluid usually occurs when oral rehydration has failed. This preserves plasma and interstitial fluid volumes. Also, if the duration of IV fluids will be short, fluids without potassium can be given. 2014 Dec 18;(12):CD009457. It suggests water loss over sodium loss. This may be due to:Greater fluid requirements secondary to a higher metabolic rateHigher insensible losses due to increased surface areaLack of ability to relate or communicate their thirst to the caregiversThe physiology of children presenting with dehydration and shock is different from adults. In children, hypotension is a late finding.Emergent intravenous fluid administration is required if there is any evidence of inadequate or poor perfusion suggested by:Delayed capillary refillTachycardiaPoor colorOliguriaHypotensionTachycardia and delayed capillary refill indicate moderate dehydration. Monitoring is essential for the patient's safety while adjusting the rate of rehydration.Review Questions1.Chen L, Hsiao A, Langhan M, Riera A, Santucci KA. Managing acute gastroenteritis among children: oral rehydration, maintenance, and nutritional therapy. Current Issues in Intravenous Fluid Use in Hospitalized Children. Correcting the intravascular volume loss with fluids improves cardiac output and reduce mortality.Dehydration due to diarrhea mainly occurs due to the contraction of intravascular fluid volume while maintaining intracellular volume. 2010 Oct;17(10):1042-7. Treatment of Pediatric Septic Shock With the Surviving Sepsis Campaign Guidelines and PICU Patient Outcomes. Use of bedside ultrasound to assess degree of dehydration in children with gastroenteritis. Rate Parental fluid administration includes bolus and maintenance rates. Value also exists in a patient unable to eat, especially young children, monitoring to determine the need for dextrose as a component of fluids. Dehydration occurs commonly in children and many times requires resuscitation. Dehydration is usually expressed as a percent of body weight loss. JAMA. [PubMed: 8444226] Hypotonic versus isotonic fluids in hospitalized children: a systematic review and meta-analysis. Fluid management is critical when providing acute care in the emergency department or hospitalized children. [PubMed: 15687435]9.Workman JK, Ames SG, Reeder RW, Korgenski EK, Masotti SM, Bratton SL, Larsen GY. A JAMA study revealed three clinical signs clinically helpful in recognizing 5% or greater dehydration: delayed capillary refill, abnormal skin turgor, and an abnormal respiratory pattern.[3] The presence of the following decreases the likelihood of clinically relevant dehydration: normal-appearing, moist mucous membranes, and absence of sunken eyes.[2]With a few exceptions, labs possess a limited role in the diagnosis of dehydration. Fluid resuscitation is essential in the management of critically ill children. Clinical features of dehydration lack sensitivity and specificity to estimate the degree of dehydration in children. Hyponatremia Although isonatremic dehydration is most common, hyponatremia or hypernatremia can occur. 2017;12(4):284-289. Evaluation and Management of Dehydration in Children. This review describes an evidence-based approach in the treatment of dehydration in children and highlights the role of the interprofessional team in evaluating and improving care for patients with dehydration. This typically occurs with diarrhea or poor breastfeeding. It has been found with both 0.2% and 0.45% normal saline.[5] The serum sodium level estimates water balance; a normal sodium level does not assess the adequacy of volume status. It is, therefore, vital to assess for signs of fluid overload such as edema or excessive weight gain. Beware that the common signs of intravascular dehydration such as tachycardia, or weak pulse occur when severe dehydration is present. Cochrane Database Syst Rev. Tonicity is related to both the impact on a cell of a fluid and the osmolality of the fluid. Rev Recent Clin Trials. The primary goal is to restore circulatory volume rapidly to prevent collapse. Administration of fluid resuscitation is essential in critically ill children. The maintenance rate can be calculated using the Holiday-Segar method.[11] This estimates physiologic losses of water scaled to the metabolic rate based on the weight of the child. This can reduce the need for intravenous therapy and hospitalization. The fluid balance should be monitored in all children receiving IV fluids. Pediatr Crit Care Med. Therefore, hypotonic fluid is not appropriate in children with volume-depletion.In 2018, the American Academy of Pediatrics published a key action statement that states, "children between twenty-eight days to eighteen years of age requiring maintenance intravascular fluids should receive isotonic solutions with appropriate potassium chloride (KCl) and dextrose." This can significantly reduce the risk of hyponatremia."[5] Based on this key action statement, the standard of care is for potassium chloride to be added to maintenance fluids unless hyperkalemia is present or renal function is compromised. 2018 Dec;142(6) [PubMed: 30478247]6.Tamer AM, Friedman LB, Maxwell SR, Cynamon HA, Perez HN, Cleveland WW. Hyponatremia is defined as a plasma sodium concentration less than 135 mEq/L. [PubMed: 24582105]13.Fuchs J, Adams ST, Byerley J. Therefore, it can be repeated as needed until adequate perfusion is restored with careful monitoring of the clinical condition and vital signs. However, this assessment of the extent of volume depletion may be difficult. Crit Care Med. Early recognition is crucial for the provision of the correct combination of fluid and electrolytes in the appropriate time and rate. Fluid bolus should be rapidly infused at 10 to 20 mL/kg of isotonic saline (0.9%).[2] This should be infused over 20 minutes in children with moderate dehydration and as fast as possible in the presence of severe dehydration. [PubMed: 27062616]12.Foster BA, Tom D, Hill V. However, baseline hydrated weights are rarely available in the emergency department.[1]Clinically, the degree of dehydration is often divided into the following;Mild 5%Moderate 10%Severe >15%Minimal dehydration is defined as a loss of less than 3% of body weight.The assessment of the severity of dehydration is essential, as therapy instituted should be based on its severity. Fluid Overload Generally, kidneys are capable of maintaining euvolemia; however, aggressive fluid administration can cause fluid overload.[5] Avoiding excessive fluid administration is critical; this is particularly more important in infants. An improvement in clinical status and resolution of signs of dehydration, such as tachycardia and dry mucous membranes, can be easily monitored. As a result, studies have shown oral rehydration therapy (ORT) in this manner is as effective as IV rehydration when oral fluids are tolerated.[6]Acute gastroenteritis commonly causes dehydration in children. 2004 Apr 15;2:11. It commonly increases morbidity and mortality in children. Infants and young children are quite sensitive to even a small degree of dehydration. [PMC free article: PMC6513027] [PubMed: 30073665]16.Riegger LQ, Voepel-Lewis T, Kulik TJ, Malviya S, Tait AR, Mosca RS, Bove EL. [PubMed: 27500722]10.King CK, Glass R, Bresee JS, Duggan C., Centers for Disease Control and Prevention. Children have a higher cardiac reserve, allowing them to compensate for significant volume loss much longer than adults. The guidelines for potassium vary greatly, and some recommended 10 mEq/L for children less than 10 kg, but the majority recommend 20 mEq/L of KCl regardless of weight.[11] An update of a Cochrane review in 2018 concluded that the use of starches, dextrans, albumin, or gelatins as opposed to crystalloids has little if any effect on mortality.[15] Small randomized and nonrandomized studies in term and preterm neonates showed some benefit with the use of albumin vs. It is related to its effect on the volume of a cell. Dehydration occurs due to significant depletion of water and electrolytes. This includes protein loss due to liver or renal disease, congestive heart failure, and renal failure.[5] Hypernatremia Hypernatremia a serum sodium level of more than 145 mEq/ L. Access free multiple choice questions on this topic. Colloids versus crystalloids for fluid resuscitation in critically ill people. 2016 Oct;17(10):e451-e458. A hypotonic solution results in swelling of cell and administration of a hypertonic solution cause a shrinkage of the cell due to extracellular fluid shift.[5] Electrolytes are responsible for determining tonicity; dextrose generally does not substantially affect tonicity as it is rapidly metabolized by insulin upon entering into intravascular space unless diabetes exists.[5] Solutions with a 1 to 1 glucose to sodium ratio (75 mEq/L according to WHO recommendations) work with physiological glucose and sodium transporters to increase intestinal mucosa absorption. Randomised controlled trial of albumin infusion in ill preterm infants. The human body has a strict physiologic control to maintain a balance of fluid and electrolytes. The clinical findings of dehydration are a manifestation of extracellular volume loss. 1985 Jul;107(1):14-9. It is a common electrolyte abnormality in children receiving IV fluids. Many specific chronic comorbidities can increase the risk of fluid overload. Oliguria also indicates that dehydration is severe, and requires intravenous fluids.The presence of severe dehydration and children in shock should be given IV fluids due to the need for rapid restoration of intravascular volume.[9] This will restore adequate tissue perfusion. [PubMed: 14627948]11.McNab S. [PMC free article: PMC419333] [PubMed: 15086953]8.Spandorfer PR, Alessandrini EA, Joffe MD, Localio R, Shaw KN. [PubMed: 29622321]3.Steiner MJ, DeWalt DA, Byerley JS. Oral rehydration versus intravenous therapy for treating dehydration due to gastroenteritis in children: a meta-analysis of randomised controlled trials. Clinical Practice Guideline: Maintenance Intravenous Fluids in Children. The isotonic solution has a sodium concentration similar to plasma. [PubMed: 25519949]15.Lewis SR, Pritchard MW, Evans DJ, Butler AR, Alderson P, Smith AF, Roberts I. A hypotonic fluid or dextrose-containing fluid should not be used for bolus unless the rapid correction of hypoglycemia is needed. The transport of sodium and glucose occurs at the intestinal brush border.Oral solutions contain adequate sodium, glucose, and osmolarity to maximize this co-transportation and to avoid problems of excessive sodium intake or additional osmotic diarrhea. Is this child dehydrated? In some children, when the physical examination is otherwise unremarkable, Ondansetron may be administered to control vomiting. Fluid and electrolyte issues can be challenging. Since the intravascular space is relatively maintained, shock may occur late and may be sudden.Dehydration is common in children. However, with the administration of isotonic fluids, the risk of hypernatremia is low.[5] In general, infants are at particular risk because of an inadequate water replacement.

01/12/2018 · Clinical Practice Guideline: Maintenance Intravenous Fluids in Children. Pediatrics. 2018 Nov 26. pii: e20183083. doi: 10.1542/peds.2018-3083. 2. McNab S, Ware RS, Neville KA, Choong K, Coulthard MG, Duke T, Davidson A, Dorofaeff T. Isotonic versus hypotonic solutions for maintenance intravenous fluid administration in children. 30/11/2018 · New Pediatric Intravenous Fluid Guideline. The AAP strongly recommends the use of isotonic maintenance intravenous fluids for most pediatric patients. Sponsoring Organization: American Academy of Pediatrics (AAP) Target Population: Medical and surgical patients aged 28 days to 18 years on critical care and general inpatient services. 23 hàng · Daily fluid requirements. 100 cc/kg for 1st 10 kg of the patient's weight; 50 cc/kg for ... 09/12/2015 · This guideline covers general principles for managing intravenous (IV) fluids for children and young people under 16 years, including assessing fluid and electrolyte status and prescribing IV fluid therapy. It applies to a range of conditions and different settings. It does not include recommendations relating to specific conditions. 01/11/2021 · The American Academy of Pediatrics has created an evidence-based guideline recommending the use of isotonic fluids for patients 28 days to ...

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