GERD < 12 MONTHS (INFANTILE REFLUX) REFERRAL GUIDELINE

MAINE MEDICAL PARTNERS - PEDIATRIC SPECIALTY CARE (DIV. OF GASTROENTEROLOGY) • 887 CONGRESS ST, SUITE 300, PORTLAND, ME • (207) 662-5522

HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

Bilious vomiting

Projectile vomiting

Weight loss

Concerning physical exam

SUGGESTED PREVISIT WORKUP

Contact pediatric GI to speak to on call for urgent appointment

Bilious vomiting is not associated with reflux. ED evaluation likely necessary.

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

Poor feeding, pain with feeding

Slowing weight gain velocity

Normal exam

Onset after 6 months of age

SUGGESTED WORKUP

Consider ultrasound and upper GI to evaluate for pyloric stenosis, malrotation, hydronephrosis

2-4 week trial of hydrolyzed formula or elimination of milk and soy from breastfeeding mother's diet, consideration of amino acid based formula if former is unsuccessful

Consider referral, eConsult, or discussion in ECHO

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

Infant with painless regurgitation with normal weight gain and normal exam

SUGGESTED MANAGEMENT

Reassurance

Avoid overfeeding

Consider thickening feeds

2-4 week trial of hydrolyzed formula or elimination of milk and soy from breastfeeding mother's diet, consideration of amino acid based formula if former is unsuccessful

CLINICAL PEARLS

- Physiologic reflux increases through the first 4-6 months of life before starting to decrease
- Acid suppression does not stop vomiting and there is minimal evidence that it has any effect on irritability or reflux symptoms in infants
- Non-IgE mediated food protein intolerance can mimic and exacerbate infantile reflux and is not always associated with stool changes

Maine Medical PARTNERS

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