

# 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**

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.