

# POAC CLINICAL GUIDELINE

## Acute Adult Dehydration

### EXCLUDE:

- Children (refer Paediatric pathway)
- Diabetes
- Renal Failure
- Septicaemia
- Signs of shock
- Heart Failure
- Undiagnosed abdominal pain
- Intracranial causes

### AIMS

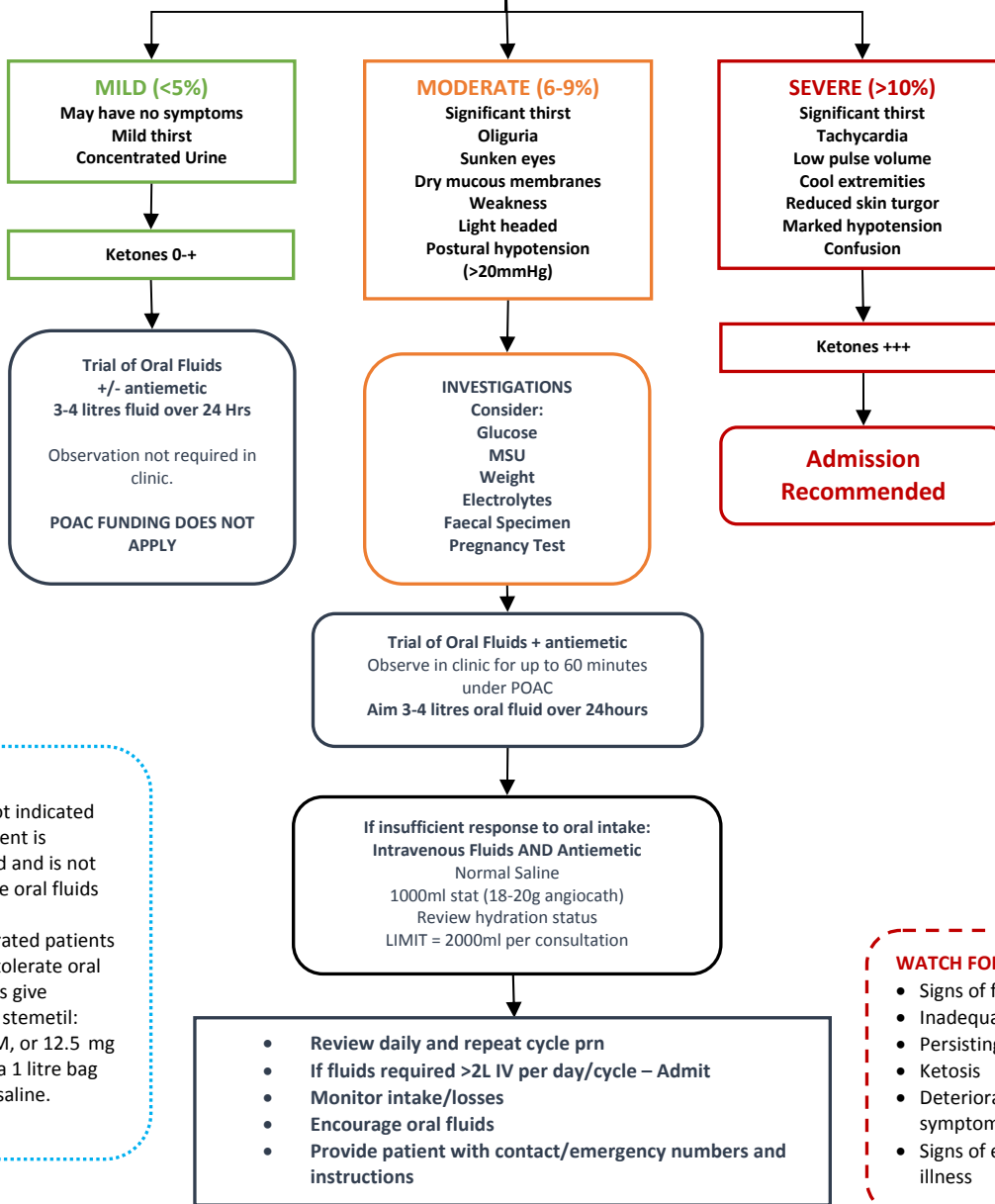
- Improvement in clinical signs
- Achieve adequate urine output
- (Record fluid balance)
- Reduction in fluid losses
- Able to manage oral rehydration solution safely at home

### CAUTION:

- Older Adults
- Pre-existing heart failure
- Prolonged duration of symptoms
- Significant Co-morbidity
- Features of evolving illness
- Recent overseas travel

- Persistent Vomiting and/or Diarrhoea
- Hyperemesis – intractable vomiting in pregnancy <20weeks

### Assess dehydration status



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### Aim

To enable the patient to continue to manage adequate oral fluid rehydration safely at home.

### Dehydration

This guideline is specific to body fluid losses secondary to hyperemesis, vomiting and / or diarrhoea. It aims to serve as a general guideline and support aid in the assessment and management of mild to moderate dehydration. Severe dehydration is the result of large fluid losses and may be complicated by electrolyte and acid base disturbances which require treatment and observation over a prolonged period. Severe dehydration is not suitable for care under Primary Options and admission to hospital is recommended.

### Exclusions

Vomiting and/or diarrhoea are symptoms which may result from a wide range of diagnoses. A working diagnosis is important in the management of subsequent dehydration. Patients with the following are excluded and admission should be considered:

- Children <15 years (refer to paediatric pathway)
- Diabetes
- Renal failure
- Septicaemia
- Shock resulting from blood loss
- Heart failure
- Cases of abdominal pain where there is not a clear diagnosis
- Intracranial causes

Caution is also recommended for cases involving older adults, pre-existing heart failure, where symptoms have been prolonged or involved overseas travel, where there is additional significant co-morbidity or where the social setting may impair management at home.

### Dehydration status

Assessment should include consideration of duration of symptoms combined with prospective total daily losses.

- Average 70kg person normal daily losses range 2500-3000ml.
- Average vomit equal or greater than 200ml
- Average diarrhoea equal or greater than 300ml

For POAC funding clinical notes must give detail supporting the diagnosis and degree of dehydration.

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### Investigations

Investigations may not be necessary. Clinical judgement is recommended following the assessment of each case. If required, simple tests which are easy to perform include;

- Faecal Culture
- MSU – infection / ketones
- Glucose – finger prick
- Electrolytes - Electrolyte disturbances and renal impairment may result from excessive fluid losses and may be especially important in older patients.
- Pregnancy test

### Fluid replacement

For both mild and moderate dehydration consider a trial of oral rehydration combined with an anti-emetic. (Metoclopramide in pregnancy, and metoclopramide or prochlorperazine or ondansetron in Non-pregnant cases) Specific oral fluid solution is at the Physicians discretion. Normal saline is the intravenous fluid of choice, however Plasmalyte is an acceptable alternative.

It is recommended that the intravenous resuscitation fluid volume is restricted to an upper limit of 2000ml per consultation. Fluid volumes beyond this level are likely to require more investigation and clinical monitoring. Should the clinician feel further fluid volumes beyond this level are needed then discussion with the appropriate specialist or hospital admission is recommended.

In all cases of intravenous fluid replacement, details of fluid balance should be recorded. Observation and reassessment of hydration status at regular intervals will allow calculation of fluid volume requirements and reduce risks of fluid overload.

### Migraine

IV fluids are not indicated in patients presenting with headache/migraine and no evidence of dehydration. POAC does not fund IV fluids in these circumstances. For patients who are vomiting to the extent that parenteral anti-emetics and IV fluids are required, unless contraindicated prochlorperazine (stemetil) can be administered either as 12.5 mg IM, or 12.5mg as a slow IV push followed by a litre of normal saline or 12.5mg IV in a litre of normal saline. Whilst IV administration is not listed in the New Zealand Formulary as a routine route of administration for prochlorperazine, IV use for migraine is supported by literature\* and by local ED specialists.

\*The acute treatment of migraine in adults: The American Headache Society Evidence Assessment of Migraine Pharmacotherapies. MJ Marmura, SD Silberstein, TJ Schwedt. Headache 55 (1) 2015: 3-20  
<http://onlinelibrary.wiley.com/doi/10.1111/head.12499/abstract>

#### DISCLAIMER:

This management guideline has been prepared to provide general guidance with respect to a specific clinical condition. It should be used only as an aid for clinical decision making and in conjunction with other information available. The material has been assembled by a group of primary care practitioners and specialists in the field. Where evidence based information is available, it has been utilised by the group. In the absence of evidence based information, the guideline consists of a consensus view of current, generally accepted clinical practice.

This guideline should not replace professional clinical judgment in managing each individual patient.

#### ENDORSEMENT:

POAC This guideline has been endorsed by the POAC Clinical Reference Group, July 2015  
July 2015