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

MILD (<5%)
May have no symptoms
Mild thirst
Concentrated Urine

Ketones 0-+

Trial of Oral Fluids
+/- antiemetic
3-4 litres fluid over 24 Hrs

Observation not required in clinic.

POAC FUNDING DOES NOT APPLY

MODERATE (6-9%)
Significant thirst
Oliguria
Sunken eyes
Dry mucous membranes
Weakness
Light headed
Postural hypotension
(>20mmHg)

INVESTIGATIONS
Consider:
Glucose
MSU
Weight
Electrolytes
Faecal Specimen

SEVERE (>10%)
Significant thirst
Tachycardia
Low pulse volume
Cool extremities
Reduced skin turgor
Marked hypotension
Confusion

Ketones +++

Admission Recommended

Trial of Oral Fluids + antiemetic
Observe in clinic for up to 60 minutes under POAC
Aim 3-4 litres oral fluid over 24hours

If insufficient response to oral intake:
Intravenous Fluids AND Antiemetic
Normal Saline
1000ml stat (18-20g angiocath)
Review hydration status
LIMIT = 2000ml per consultation

- Review daily and repeat cycle prn
- If fluids required >2L IV per day/cycle – Admit
- Monitor intake/losses
- Encourage oral fluids
- Provide patient with contact/emergency numbers and instructions

Migraine
Give IV stemetil 12.5 mg

IV fluids not indicated unless patient is dehydrated and is not able to take oral fluids

WATCH FOR
- Signs of fluid overload
- Inadequate response
- Persisting fluid losses
- Ketosis
- Deterioration of symptoms
- Signs of evolving illness

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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.

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