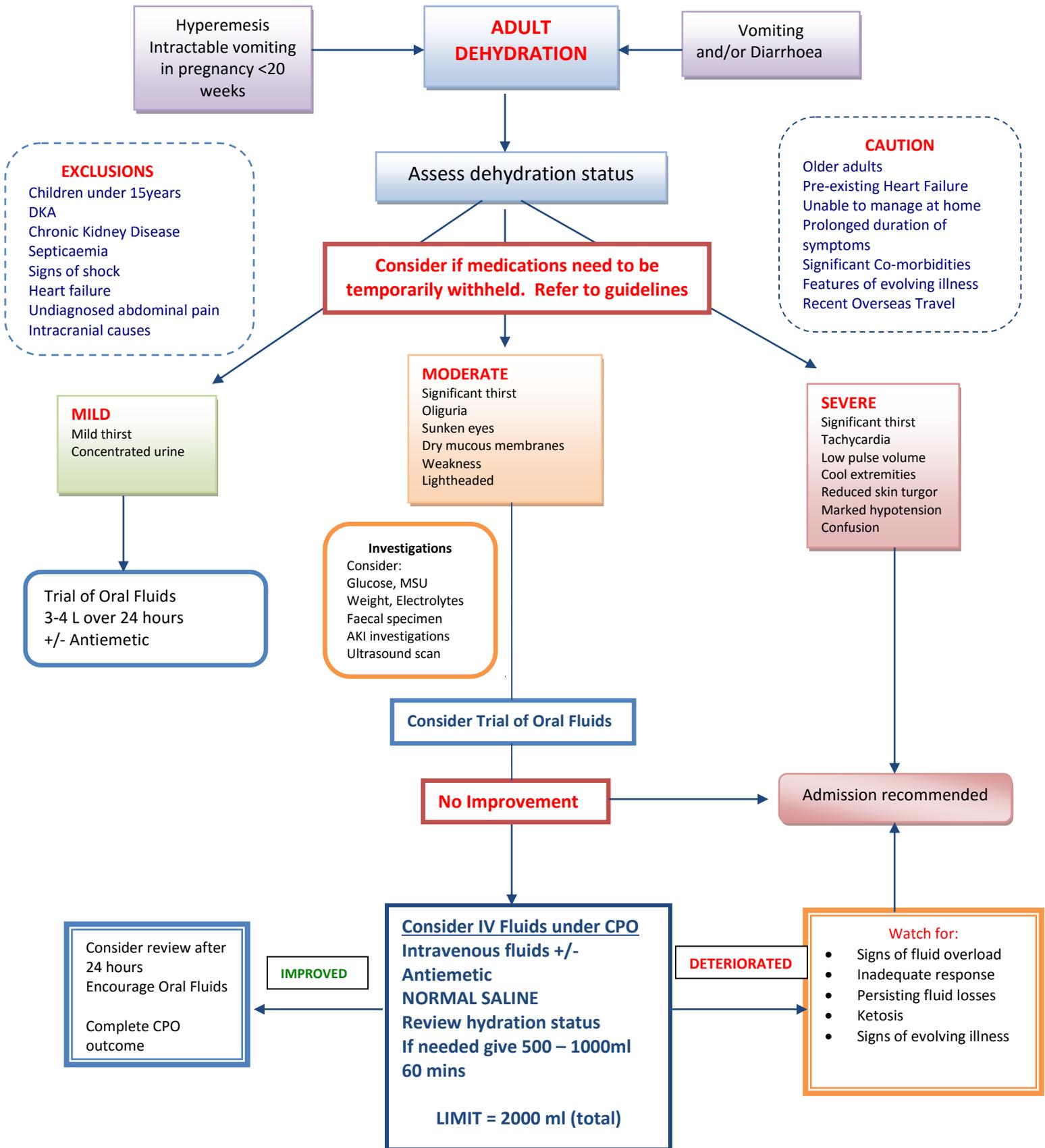


CPO Adult Rehydration Pathway



Acute Adult Rehydration Pathway

This pathway aims to serve as a general guideline in the assessment and management of **mild to moderate dehydration**, which is suitable for CPO. This pathway is specific to body fluid losses e.g. vomiting and / or diarrhoea, hyperemesis, other clinical need depending on clinical assessment and individual patient factors.

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 CPO and admission to hospital is recommended.

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.

Dehydration status

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

Out of scope:

- severe dehydration is not suitable for care under CPO and admission to hospital is recommended
- children <15 years
- DKA
- chronic kidney disease:
 - CKD 3 (gfr 30-59) - use pathway with caution
 - CKD 4 (grf 15-29) - avoid IV rehydration without consultation with on-call medical team
- septicaemia
- signs of shock
- heart failure
- undiagnosed abdominal pain
- intracranial causes

CAUTION RECOMMENDED FOR:

- older adults
- pre-existing heart failure
- unable to manage at home
- prolonged duration of symptoms
- significant co-morbidities
- features of evolving illness
- recent overseas travel

Key Medications to consider temporarily discontinuing during acute illness in at-risk patients

- Sulfonylureas
- ACE inhibitors
- Diuretics
- Metformin
- Angiotensin Receptors Blockers (ARBs)
- Non-steroidal anti-inflammatory agents (NSAIDs)
- Dabigatran

(To remember, the acronym is SADMAN + Dabigatran).

Investigations

Investigations are not always necessary.

Following the assessment of each case, clinical judgment is recommended to decide if further investigations are necessary. If necessary, these may include:

- Creatinine and Electrolytes - renal impairment may result from excessive fluid losses and may be especially important in older patients.
- Blood Glucose
- MSU – infection / ketones
- Faecal culture
- Weight
- Reminder- intractable vomiting may also be associated with multiple pregnancy.

Fluid replacement

Oral

- For both mild and moderate dehydration consider a trial of oral rehydration combined with an anti-emetic.
- May include an electrolyte solution

Intravenous Fluids (CPO Funded)

- Normal saline is the intravenous fluid of choice.
- Specific oral fluid solution is at the Clinicians discretion

<p style="text-align: center;">FLUID VOLUME LIMIT 2000 ML</p>
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It is recommended that the intravenous fluid volume is restricted to an upper limit of 2000ml per consultation. Fluid volumes beyond this level are likely to require more investigation, clinical monitoring and electrolyte management. Should fluid volumes beyond this level be needed then discussion with the appropriate specialist or hospital admission is recommended. Anti-diarrhoeal's not recommended

Watch for signs of:

- fluid overload
- inadequate response
- persisting fluid losses
- ketosis
- evolving illness

Anti-emetics

Ondansetron:

- A single dose of 4-8mg Ondansetron is usually enough to allow oral rehydration therapy when given in mild to moderate dehydration, prescribing additional doses is usually not required

Metoclopramide:

- Should only be prescribed for short term use (up to 5 days)
- Usual dose is 5-10 mg repeated up to 3 times daily; use lower dose in 16-20 year olds and those under 60kg
- Intravenous doses should be administered as a slow bolus over at least 3 minutes
- Metoclopramide can rarely cause severe dystonias, e.g. oculogyric crisis. These can be treated with 1-2mg of IM or IV benztropine (benztropine)

Prochlorperazine: (Stemetil, Antinaus, Buccastem)

Available in oral, buccal, and IV formulation. Adult dose for treatment of nausea / vomiting is:

- Oral tablet: Adult acute attack 20 mg initially then 10 mg after 2 hours; prevention 5–10 mg 2–3 times daily
- Buccal tablet: Adult 3–6 mg twice daily; tablets are placed high between upper lip and gum and left to dissolve
- Deep intramuscular injection: Adult 12.5 mg when required followed if necessary after 6 hours by an oral dose, as above

If Deteriorating:

Transfer to hospital and contact AAU on-call physician 06 8734812 or 027 7654459 (Mon-Fri 8am-5pm). Out of hours contact triage nurse via switchboard 06 8788109 extn 2623.

*For further information regarding rehydration refer to:
Rehydration for Adults Clinical Pathway on Map of Medicine.*