Mild regurgitation of milk in infants (0-12 months) is benign and self-limiting and requires no specific intervention. GORD describes the reflux of gastric contents leading to troublesome symptoms such as faltering growth or respiratory disorders or pain.

- pH meters and, more recently, intraluminal electrical impedance monitoring are used in secondary and tertiary care to aid diagnosis but most children are treated on clinical grounds.
- Check that the baby is not being overfed (150mls/kg/24 hours) and does not have refluxing feeds. A normal infant feeds approximately 150mls/kg/24 hours.
- Eliminating cows’ milk protein (CMP) from the infant’s diet should lead to a decrease in symptoms of GORD within 2 weeks in babies of younger than 6 months. This is the recommended treatment in cases of severe symptoms. If symptoms persist after 2 weeks of CMPA management, then elimination diets such as Enfamil AR and SMA chick should be considered rather than the use of thickened feeds.
- Check that the baby is not being overfed (150mls/kg/24 hours) and does not have refluxing feeds. A normal infant feeds approximately 150mls/kg/24 hours.
- Proton pump inhibitors (eg. omeprazole): might reduce the number, but not the severity, of vomiting episodes. Should not be given >6 times in 24 hours.
- H2 receptor antagonists (eg. ranitidine): the authors found no RCTs for their use in infants but in practice, they may be used with good effect.
- Anti-reflux formula feeds such as Enfamil AR and SMA Chick should be considered rather than the use of thickened feeds.
- Staydown should not be used with other thickeners or gaviscon (eg. gaviscon): might reduce the number, but not the severity, of vomiting episodes.
- Allergies can often improve with time, especially if recurrent, worst at night or early morning and occur with exercise, laughter or emotion or with exposure to pets, cold or damp air.
- Check that the baby is not being overfed (150mls/kg/24 hours) and does not have refluxing feeds. A normal infant feeds approximately 150mls/kg/24 hours.
- Acid reflux can cause pulmonary symptoms such as cough, wheeze, breathlessness and chest tightness, especially if recurrent, worse at night or early morning and occur with exercise, laughter or emotion or with exposure to pets, cold or damp air.
- Isolated cough
- Dizziness, peripheral tingling
- Repeatedly normal chest examination and PEFR (click here for age-linked normal peak flow chart)
- No response to bronchodilators

**HIGH PROBABILITY:** start trial of treatment and reassess

**INTERMEDIATE PROBABILITY:** assess reversibility eg. higher PEFR after a β2 agonist is administered or with exercise. If reversibility is good, then step down to maintenance dose.

**LOW PROBABILITY:** consider further investigations/referral if symptoms persist <5 year olds are difficult to assess; possible approaches include watchful waiting with review, trial of treatment or lung function tests if child able.

**Aim of asthma management = control of disease**

- = no daytime symptoms
- = no night time waking
- = no need for rescue meds
- = no limitations on activity
- = PEFR >80% of predicted/best
- = minimal side effects from medications

Therefore: start treatment, achieve early control and step down when possible (see clear charts on stepwise management in the quick reference guide)

**ASSESSMENT OF ACUTE EXACERBATION:**

**FEATURES OF ACUTE SEVERE ASTHMA**  
- SpO2 < 92%  
- PEFR 33-50% predicted
- Can’t speak in full sentences
- Heart rate > 125bpm (> 5 yr olds), >140bpm (2-5 yr olds)
- Resp. rate > 30 ( > 5yrs), > 40 (2-5 yrs)

**FEATURES OF LIFE THREATENING ASTHMA**  
- SpO2 < 92%  
- PEFR 33-50% predicted
- Hypotension, exhaustion, confusion, cyanosis, silent chest, coma

**MANAGEMENT OF ACUTE SEVERE ASTHMA:** First line treatment is inhaled (nebulised with oxygen if O2 sats < 92%) β2 agonist and early oral steroids. Oral β2 agonists are not recommended.