Pediatric Gastroenterology
Consult and referral guidelines

Helen DeVos Children's Hospital
Outpatient Center
35 Michigan Street NE

Outreach locations:
Lansing, St. Joseph, Traverse City

About Pediatric Gastroenterology

We accept referrals for children up to age 18.

Most common referrals

- Abdominal pain
- Constipation/encopresis
- Diarrhea
- Vomiting
- GERD
- Suspected inflammatory bowel disease, celiac disease or eosinophilic esophagitis
- Elevated liver enzymes or cholestasis
- Failure to thrive
- Dysphagia/feeding problems
- Short bowel syndrome/intestinal failure

Pediatric Gastroenterology Appointment Priority Guide

Immediate	Contact HDVCH Direct at 616.391.2345 and ask to speak to the on-call gastroenterologist and/or send to the closest emergency department.
Urgent	Likely to receive an appointment within 2 days. Send referral via Epic Care Link, fax completed referral form to 616.267.2401, or send referral through Great Lakes Health Connect
Routine	Likely to receive an appointment within 10 days. Send referral via Epic Care Link, fax completed referral form to 616.267.2401, or send referral through Great Lakes Health Connect

Diagnosis/Symptom	Suggested Workup/Initial Management	When to Refer	Information Needed
Abdominal Pain	Diet modification: eliminate carbonated beverages, caffeine, gum chewing, and decrease intake of greasy or gas-producing foods, consider trial of dairy-free diet Consider: • Counseling to address potential stress/anxiety issues and to learn relaxation techniques • Trial of a probiotic • Trial of an antispasmodic (hyoscyamine or dicyclomine) • Trial of a stool softener (PEG 3350) If not improving with the above recommendations, consider CBC/differential, CRP, ESR, CMP, lipase, total IgA, transglutaminase antibody, include deamidated gliadin antibody if patient <3 years of age, urinalysis, fecal hemoccult x3 Would not recommend imaging unless lab abnormalities or symptoms suggest a more specific diagnosis	For patients 0 to 4 years: • If persistent for more than two weeks, or if accompanied by persistent fever, diarrhea, vomiting, weight loss/growth failure or GI bleeding For patients >5 years: • If pain is persistent for more than 6 weeks and no improvement with conservative IBS management techniques, or if accompanied by persistent fever, diarrhea, vomiting, weight loss/growth failure or GI bleeding	• Growth chart • All lab and radiology reports • List of treatments tried

Diagnosis/Symptom	Suggested Workup/Initial Management	When to Refer	Information Needed
Constipation/ Encopresis *For more information, please see "Constipation in Children" here.*	Diet modification: decrease intake of dairy, increase intake of water/high fiber foods Colonic clean out*, if indicated, and then daily use of stool softener Behavioral techniques (regular toilet time/sticker chart system) If not improving with the above recommendations: • Consider KUB if needed to assess fecal load or if obstruction suspected. • Consider barium enema if Hirschsprung's Disease or neurogenic bowel suspected – MRI if concerned about tethered cord • Consider CBC/differential, CMP, TSH, total IgA, transglutaminase antibody, deamidated gliadin antibody if patient <3 years of age • Consider sweat chloride	• If not responding to standard bowel regimen, or accompanied by obstructive symptoms or urinary incontinence	• Growth chart • All lab and radiology reports • List of treatments tried

Constipation Regimen Guidelines

Colonic clean out:*
- *PEG 3350 one capful (17 gms) per year of age daily (maximum dose 14 capfuls/day)*
- *Mix in Gatorade or other clear liquid, can mix 17 gms per 4 ounces of liquid for the duration of the clean out*
- *Give daily for three consecutive days*
- *Can stop clean out early if passing clear stools*
- *Maintain a primarily clear liquid diet during clean out to obtain best results*

Maintenance:
- *PEG 3350 one capful (17 gms) daily mixed in 8 ounces clear liquid*
- *Dose can be titrated by ½ capfuls as needed to achieve soft daily stools*

**Use caution to avoid dehydration during clean out in patients <2 years of age, with fixed fluid intake, or with renal disease.*

Diagnosis/Symptom	Suggested Workup/Initial Management	When to Refer	Information Needed
Diarrhea	Trial of two-week dairy free diet and/or decrease clear liquids, caffeinated beverages and simple sugars If blood in stool, or if patient fails to respond to dietary management: • Fecal hemoccult x3, fecal lactoferrin or calprotectin, bacterial culture or enteric pathogen PCR, O&P (complete if patient is immunocompromised or has history of recent foreign travel), C. diff screen if patient >2 years of age, CBC/differential, CMP, CRP, ESR, total IgA, transglutaminase antibody, deamidated gliadin antibody if patient <3 years of age • Consider sweat chloride. • Consider fecal pancreatic elastase if there are growth concerns (weight or height)	• After infectious etiologies have been ruled out and appropriate dietary management has been initiated • And, if persistent for more than 2 weeks, or accompanied by blood in stool or associated weight loss/growth failure	• Growth chart • All lab and radiology reports • List of treatments tried
Vomiting	Consider trial H2 antagonist or proton pump inhibitor Consider CBC/differential, CRP or ESR, CMP, lipase, total IgA, transglutaminase antibody, deamidated, gliadin antibody if patient <3 years of age, urinalysis Although not routinely recommended, if you feel helicobacter pylori testing is necessary, obtain fecal h. pylori antigen or urease breath test *not h. pylori serology* *Would **NOT** recommend helicobacter pylori testing in patients <1 year of age* Consider KUB or UGI if anatomic etiology suspected	• If persistent for more than 2 weeks • If experiencing recurrent episodes more than four times per year • If accompanied by bilious emesis or hematemesis may need immediate referral to emergency department.	• Growth chart • All lab and radiology reports • List of treatments tried

Diagnosis/Symptom	Suggested Workup/Initial Management	When to Refer	Information Needed
GERD	Conservative GERD measures (see article) Consider trial H2 antagonist or proton pump inhibitor if H2 antagonist not effective Consider UGI if dysphagia present or anatomic etiology suspected	• If accompanied by weight loss or failure to thrive, respiratory symptoms, severe irritability in an infant or nonverbal patient, dysphagia, or pain despite observing conservative anti-reflux measures and using appropriate acid suppressive therapy. • If dependent on acid suppression for control of symptoms (has failed 2 or more attempts to wean acid suppression). • *If accompanied by bilious emesis or hematemesis may need immediate referral to emergency department.*	• Growth chart • All lab and radiology reports • List of treatments tried
Inflammatory Bowel Disease	Fecal hemoccult x 3, lactoferrin or calprotectin (calprotectin preferred, if a covered benefit), bacterial culture or enteric pathogen PCR (bacterial culture preferred if a covered benefit), O&P (complete if patient is immunocompromised or has history of recent foreign travel), C. diff screen if patient >2 years of age), CBC/differential, CMP, CRP, ESR, total IgA, transglutaminase antibody, deamidated gliadin antibody if patient <3 years of age *Please do not initiate corticosteroid therapy for IBD before consulting with Pediatric Gastroenterology.*	• *Immediate referral:* If inflammatory bowel disease is strongly suspected	• Growth chart • All lab and radiology reports • List of treatments tried
Elevated Liver Enzymes	Provided on a case-by-case basis In patients with BMI ≥95% or acute significant weight gain with mild elevation of transaminases (less than twice the upper limit of normal), initiate lifestyle modification strategies (most importantly elimination of sugar-sweetened beverages) and re-check in 1-6 months.	• Elevated liver enzymes (ALT greater than 44 for girls, 52 for boys) for over 1 month	• Growth chart • All lab and radiology reports • List of treatments tried

Diagnosis/Symptom	Suggested Workup/Initial Management	When to Refer	Information Needed
Cholestasis	Provided on a case-by-case basis Initial ultrasound of the liver with doppler may be helpful if it can be performed promptly. Initial lab tests include: CMP **with direct bilirubin,** GGT, CBC, PT/INR	• *Urgent referral:* Any infant or child with cholestasis (elevated direct bilirubin, >20% of total bilirubin). Do not delay referral if labs are unable to be obtained. • Contact HDVCH Direct (616.391.2345) and ask for on-call gastroenterologist regarding any cholestatic infant.	• All prior lab testing including imaging studies • Growth chart • Previously obtained laboratory studies
Failure to Thrive	For infants, fortify calories in formula or supplement breast feeding with bottle feeding For toddlers and older children, supplement with Pediasure or equivalent formula Consult with a dietician Consider CBC/differential, CMP, CRP, ESR, TSH, total IgA, transglutaminase antibody, deamidated gliadin antibody if patient <3 years of age, sweat chloride, fecal pancreatic elastase, urinalysis	• If patient fails to respond to dietary modification *Consider Pediatric Endocrinology referral*	• Growth chart • All lab and radiology reports • List of treatments tried
Celiac Disease	Consider CBC/differential, CMP, CRP, ESR, total IgA, transglutaminase IgA antibody, include deamidated gliadin antibody if patient <3 years of age First degree relatives: Screen asymptomatic patients >3 years of age, or symptomatic patients <3 years of age. total IgA, transglutaminase IgA antibody, include deamidated gliadin antibody if patient <3 years of age *Please do not initiate gluten free diet before consulting with Pediatric Gastroenterology*	• If celiac antibody testing is positive	• Growth chart • All lab and radiology reports • List of treatments tried

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Diagnosis/Symptom	Suggested Workup/Initial Management	When to Refer	Information Needed
Feeding Problems or Dysphagia	Obtain outpatient feeding evaluation and swallow study Consider esophagram Consider trial of H2 antagonist or PPI	• If patient fails to improve with feeding therapy and/or acid suppression • If esophagram demonstrates stricture or other abnormality	• Growth chart • All lab and radiology reports • List of treatments tried