Management of Acute Severe Gastroenteritis (Clinically suspected Cholera)

(July 2024)(Version 1.1)

Acute watery diarrhea (± vomiting) with rapid and severe dehydration (in the absence of other causes of diarrhea) (Cholera diarrhea has typical rice water stool + fishy odor)

- Follow infection prevention and control measures; strict hand washing is advised. Keep in separate room.
- Check airway, breathing, circulation, assessment of Temperature, HR, BP, RR, UO and severity of dehydration *
- Collect blood samples - CP (A), CRP, U&E, Cr, RBS and stool sample for C&S/rectal swab and do ECG in necessary cases.
- May need further investigations if red flag features present**

Fluid replacement: Insert IV wide bore cannula in both arms
Some dehydration >> ORS 2500- 5000ml within 1st 4 hours of presentation, then continued 500-1000 ml of ORS after each episode of diarrhea or vomiting
Severe dehydration >> IV R/L (N/S or D/S) 1500 ml within 30 min followed by 3500 ml over next 2.5 hr. Replace ongoing fluid losses with IV fluid for 6-12 hours and switch to ORS as soon as the patient is able to drink (ORS 200-400 ml per hour) and passing urine.

Antibiotics: any one available option + folic acid /Zinc 1OD
PO Doxycycline 300 mg single dose (4-6 mg/kg for > 8 yr pediatrics)
PO Azithromycin 1g single dose (20 mg/kg for pediatrics) or
PO Ciprofloxacin 500 mg BD for 3 days (15 mg/kg BD for 3 days for > 8 yr pediatrics). IV Ciprofloxacin 200 mg 12 h for those who cannot tolerate oral intake until orally safe.

- Continuously monitor hydration status, vital signs, urine output, and stool output.
- Report to Medical Superintendent.
- If bacteria with darting motility in stool microscopy or stool culture positive, transfer to designated referral hospital (*Waibargi Specialist Hospital* in Yangon) after ensuring vital signs are stable.
- Consider transfer to ward or discharge home if the patient meets all of the discharge criteria***

*No dehydration	*Mild dehydration	*Some dehydration	*Severe dehydration
• Well, alert • Drinks normally, not thirsty • Normal eyes • Skin pinch goes back quickly • Normal urine output • Normal vital signs • Estimated fluid deficit : <50 ml/kg	• Alert, responsive • Thirst • Normal eyes • Dry mouth • Slightly decreased urine output • Normal vital signs • Estimated fluid deficit : <50 ml/kg	• Restlessness, irritability • Thirsty drinks eagerly • Sunken eyes • Skin pinch goes back slowly • Reduced urine output • Increased HR and normal or slightly decreased BP • Estimated fluid deficit: 50 to 100 ml/kg	• Lethargy or unconsciousness • Very thirsty, unable to drink or drinks poorly • Very sunken eyes • Skin pinch goes back very slowly (≥ 2 seconds) • Minimal or no urine output • HR ≥ 120/min, SBP<90 mmHg and increased RR • MAP < 65 mmHg • Estimated fluid deficit: > 100 ml/kg)

Note: *Blood Urea Nitrogen (BUN) and Creatinine: Elevated levels may indicate dehydration and renal impairment. Elevated hematocrit can be a sign of dehydration.*

Mild disease	Mild dehydration
Moderate disease	Some dehydration
Severe disease	Severe dehydration with indicators of severity (HR ≥ 120/min, SBP < 90 mmHg and increased RR), MAP < 65 mmHg

**Red flag features	***Discharge criteria
• Blood in stool • High fever • Severe abdominal pain • Immunocompromised state • Signs of sepsis • Recent antibiotics use (risk of *Clostridium difficile* infection)	• No signs of dehydration • Able to take ORS without vomiting • No watery stools for 4 hours • Able to walk without assistance • Passing urine