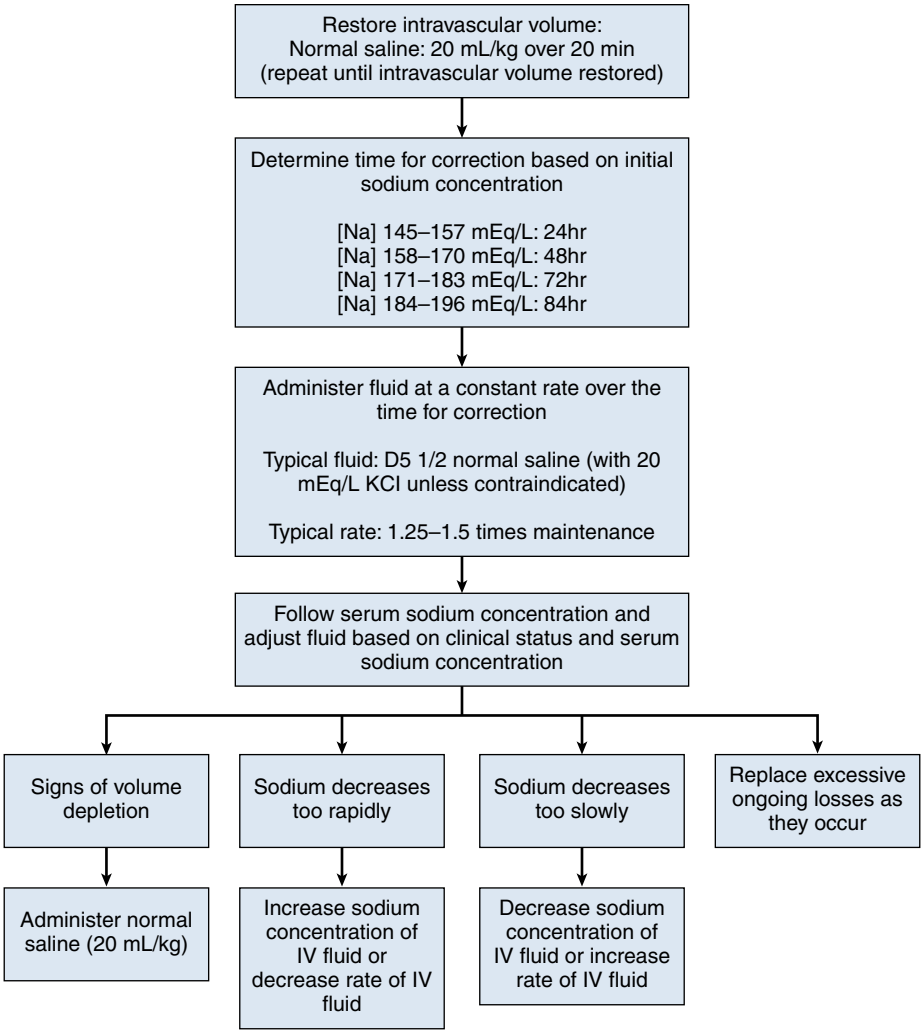

Figure 33-1 Strategy for correcting hypernatremic dehydration.

with gastric or intestinal distention. Rapidly absorbed ondansetron may be used to treat vomiting, thus facilitating oral rehydration.

As a guideline for oral rehydration, 50 mL/kg of the ORS should be given within 4 hours to patients with mild dehydration, and 100 mL/kg should be given over 4 hours to patients with moderate dehydration. Supplementary ORS is given to replace ongoing losses from diarrhea or emesis. An additional 10 mL/kg of ORS is given for each stool. Fluid intake should be decreased if the patient appears fully hydrated earlier than expected or develops periorbital edema. After rehydration, patients should resume their usual diet (breast milk, formula).

When rehydration is complete, maintenance therapy should be started, using 100 mL of ORS/kg in 24 hours until the diarrhea stops. Breastfeeding or formula feeding should be maintained and not delayed for more than 24 hours. Patients with more severe diarrhea require continued supervision. The volume of ORS ingested should equal the volume of stool losses. If stool volume cannot be measured, an intake of 10 to 15 mL of ORS/kg/hr is appropriate.

Chapter 34

PARENTERAL NUTRITION

Parenteral nutrition (PN) is necessary when enteral feeding is inadequate to meet the nutritional needs of a patient. Enteral nutrition is always preferred because it is more physiologic, less expensive, and associated with fewer complications. Fewer complications are expected if at least some nutrition can be provided enterally.

INDICATIONS

A variety of clinical situations necessitate PN (Table 34-1). Acute PN is frequently given in an intensive care unit when there is poor tolerance of enteral feeds, potentially secondary to a transient ileus; concerns regarding bowel ischemia; or the