NICE guidance on managing frequent infant regurgitation with marked distress[1]

Diagnostic criteria and characteristics of infant regurgitation

Occurs in otherwise healthy infants 3 weeks to 12 months of age[2]:

- Regurgitating 2 or more times /day for 3 or more weeks without other specified symptoms*[2]
- Usually begins before the infant is 8 weeks of age, affects 40% of infants and resolves in 90% of affected infants by 1 year of age[1]
- **In infants with vomiting or regurgitation, look out for 'red flags' symptoms** which may suggest disorders other than gastro-oesophageal reflux (GOR)[1]**

In the presence of frequent regurgitation associated with marked distress, follow this stepped - care approach[1]

For Breastfed Infants

A person with expertise and training should carry out a breastfeeding assessment

If regurgitation persists, consider a trial of alginate therapy for 1 -2 weeks. If the alginate therapy is successful continue but try stopping at intervals to see if the infant has recovered

For Formula Fed Infants

- Review the feeding history and reduce feed volumes if excessive for infant's weight
- Advice to trial smaller volumes of more frequent feeds (while maintaining the appropriate daily volume of milk)
- Advice to trial a thickened formula† e.g. containing starch thickener
- If stepped care approach is unsuccessful, stop thickened formula and trial alginate therapy for 1 – 2 weeks
- If alginate therapy is successful, continue use but stop periodically to assess recovery

*Retching, haematemesis, aspiration, apnoea, failure to thrive, feeding or swallowing difficulties, or abnormal posturing[1]

**NICE red flag symptoms: Frequent, forceful (projectile) vomiting, bile-stained vomit, haematemesis, onset of regurgitation and/or vomiting after 6 months old or persisting after 1 year old, blood in stool, abdominal distension, tenderness or palpable mass, chronic diarrhoea, appearing unwell, fever, dysuria, bulging fontanelle, rapidly increasing head circumference, vomiting worse in the morning, altered responsiveness, infants with, or at high risk of, atopy.

†Thickened formulas may require a fast flow teat

REFERENCES: 1. NICE (2015) Gastro-oesophageal reflux disease in children and young people: diagnosis and management. Available at https://www.nice.org.uk/guidance/ng1 **2.** Benninga M and Nurko S *et al.* Childhood Functional Gastrointestinal Disorders: Neonate/Toddler. Gastroenterology 2016; 150 (6): 1443–1455.

For helpful resources to support parents visit www.smahcp.co.uk/nice

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