Managing Reflux in Infants Under 1 Year

This Good Practice Point aligns to the NMC 2022 Standards of Proficiency for SCPHN Health Visitors – in particular: Sphere of Influence D: Population health: enabling, supporting and improving health outcomes of people across the life course. See the Nursing and Midwifery Council website for more details.

Reflux is common, affecting at least 40% of under 1-year-olds[1]. It can cause distress to infants and their families and is a subject which health visitors are commonly consulted on for advice. This Good Practice Point will outline what reflux is and how health visitors and their teams can use the latest evidence base to support families.

What is reflux?

- Gastro-oesophageal reflux (GOR) is when gastric contents pass from the stomach into the oesophagus. It is a common physiological event and is often asymptomatic. In infants, it happens more frequently after feeds and is associated with visible regurgitation of feeds.
- Gastro-oesophageal reflux disease (GORD) in children is the presence of GOR symptoms severe enough to require treatment (for example discomfort or pain)[2].

In well babies, GOR:

- Is very common (up to 40% of infants)
- Typically begins before 8 weeks of age
- Can be frequent (6 or more episodes per day)
- Usually improves with time (self-resolves in 90% of affected infants by 1 year of age)[3].

When does GOR become GORD?

GORD may be present if the symptoms of GOR are present, with the addition of 1 or more of the following:

- unexplained feeding difficulties (gagging, choking, feed refusal)
- distressed behaviour
- faltering growth
- chronic cough
- hoarseness or a single episode of pneumonia[2].

Diagnosis

Whilst there is no standard diagnostic criteria for infant GORD[2], a full assessment which considers the possible signs and symptoms listed is recommended. It is advocated that health visitors take a comprehensive history of the symptoms and any other relevant clinical information[4], including a full feeding history and assessment, and details of any treatments which have already been tried and their effect, as well as a full birth history. It is important for health visitors to provide families with safety-netting advice on "red flag" symptoms and signs that require medical attention. These can be seen below and will require further assessment by a GP or other appropriate specialist[2]:

Gastrointestinal red flags which may indicate conditions other than reflux[2];

- Projectile vomiting
- Bile-stained vomit
- Blood-stained vomit (excluding swallowed blood e.g. from cracked nipples)
- Onset of regurgitation/vomiting after 6 months and persisting beyond 1 year
- Blood in stools
- Chronic diarrhoea
- Abdominal distension/tenderness
- Faltering growth.

Please see NICE guidelines for more information regarding these red flags: bit.ly/4eEcoQB

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The information in this GPP version was created on 16/10/2024.

Treatment and management

NICE guidelines[2] advocate the same initial management measures for both GOR and GORD. Health visitors can support families with the following advice:

Feeding

- **Breastfed infants** can continue to self-regulate their feeds through responsive feeding (UNICEF Responsive Feeding Infosheet: bit.ly/3TP9Je9)
  - » Offering support and encouragement to continue breastfeeding is an important part of the health visitor's role, providing reassurance that, if necessary, reflux can be successfully treated alongside breastfeeding.
  - » Over-supply or a rapid flow can worsen reflux symptoms in breastfed babies. This may be helped by feeding in a more upright position or pausing the feed briefly whilst the flow slows. It is also important to review positioning and attachment to ensure the baby has a deep latch and good tongue function (i.e. assess for tongue-tie)[5]
  - » A medical professional may suggest a trial of alginate treatment (e.g. Gaviscon) if indicated and parents should be supported to follow the plan devised with the GP/paediatrician. Alginates can help by stabilising stomach activity through reacting with acidic stomach contents and forming a viscous gel barrier[3].
- **Formula fed infants** can also continue to feed responsively to aid them to regulate their appetite and the speed at which they feed. At times however, formula fed babies displaying signs of reflux may benefit from feeding 'little and often', and feeds may need to be paced, by altering the frequency, volume, or speed of feeds[2]. If this is the case, because marked distress is seen alongside frequent regurgitation, a stepped-care approach is recommended including[2]:
  - » a thorough review of the feeding history, then
  - » reduce the volume of feeds only if they are currently excessive for the infant's weight, then
  - » offer a trial of smaller, more frequent feeds – it is important that the appropriate total daily amount of milk is still offered. If the feeds are already assessed to be frequent and small, then
  - » if no improvement, refer to the GP who may suggest a trial of thickened formula.

Positioning

- Symptoms can be relieved by keeping the infant upright for as long as possible after a feed, whether they are breast or formula fed[7]. This will enable gravity to support with digestion of foods and allow the stomach contents to settle[4].
- It can be helpful for formula fed infants to be in a more upright position during feeds, and to be winded regularly[8]. More information can be found at: bit.ly/4euhv5B.
- Sleeping position should follow the current safe sleeping guidance at all times, and the sleeping surface should not be tilted by elevating the head end, due to the increased risk of the baby moving into an unsafe position[1,2,4,7,8]. More information can be found at: Safer Sleep resources (bit.ly/3Y5ozQz).

Emotional support

- Reassurance is a central element of supporting families through reflux. Parents and carers may experience a negative impact on their wellbeing resulting from their baby's symptoms, possibly through worry that the baby may not thrive, or feeling overwhelmed with a baby who is frequently distressed. Health visitors can support families by offering reassurance that reflux symptoms do improve with time[3].
- It may be helpful to undertake regular monitoring of parent/carer emotional wellbeing and, if indicated, complete a more formal assessment of mental health following local and national guidelines. Caring for a baby with reflux can take a significant emotional toll on parents[9], and health visitors are highly skilled in supporting parent-infant relationships. See the iHV GPPs Strengthening parent-infant relationships (bit.ly/46USFYv) and Understanding Babies Who Cry a Lot (bit.ly/3y0mElx) for more information.

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Good practice points

- Provide reassurance that symptoms frequently improve with time – GOR resolves in 90% of infants by the time they are 12-months-old[2].
- Explain the role of the health visitor, how families can contact the health visiting team if worried, and create a joint plan of support including any follow-up.
- An infant experiencing reflux can have a significant impact on parent/carer wellbeing[9] – remember to continuously observe and assess the mental health of those caring for the infant following local protocols.
- Support families to continue breastfeeding if this is their choice.
- Complete a full feeding assessment, including taking a feeding and birth history, and observing a feed.
- Promote safe sleeping following evidence-based guidance[2].
- Discuss responsive feeding and enable parents/carers to understand how this will support their infant to regulate their feeds.
- Monitor all aspects of growth and development and follow local pathways if there are any concerns.
- Connect families with resources to support them, such as Healthier Together (bit.ly/4duQwpf and bit.ly/3Uj3b7f).

Resources:

- iHV Webinar. Healthy Weight, Healthy Nutrition: Reflux (bit.ly/3zB5Suz - log into the iHV website to access).

References

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