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These programs feature subject matter which is coordinated with the PREP curriculum and are eligible for PREP credits.

For further information, contact: CME, Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60009-0927. (800) 433-9016. In Illinois (800) 421-0589.
This guide is one of a series of guides prepared by the American Board of Pediatrics as an integral part of the record review required for renewal of certification in general comprehensive pediatrics. Their purpose is to provide the pediatrician with criteria for assessing patient records dealing with specific problems. Important elements to be included in the record appear in the margins; those printed in italics are important under certain circumstances. Please note that these guides do not purport to articulate standards of care. They are designed solely to address record keeping issues.

The guides focus on the elements of the history and physical examination relevant to specific problems and are not meant to discourage a more thorough history and physical examination as appropriate for the patient and the particular circumstances.

The guides will be updated periodically. Because of rapid changes in knowledge about drugs and their availability, drugs and dosages included in these guides should be verified in current sources.

A table of international units is included in each guide.

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INTRODUCTION

Vomiting and diarrhea are among the most common symptoms of infancy and childhood, particularly during the first two or three years after birth. Vomiting is usually a systemic manifestation rather than a direct result of inflammation. In undeveloped countries, recurrent infectious diarrhea is an important cause of morbidity and mortality, frequently leading to chronic undernutrition. Breast-fed infants are less likely to have diarrhea than bottle-fed infants. Most episodes of diarrhea are acute self-limited illnesses caused by infectious processes which are commonly of viral etiology. When diarrhea is chronic or recurrent, one must consider anatomic defects, formula intolerance, protozoan infestation, malabsorption syndromes, endocrinopathies, neoplasms, and immune deficiency. Therefore, for the purposes of this guide, which is directed at the patient with acute gastroenteritis, consideration will be given only to cases that have lasted less than one week. Vomiting and diarrhea occurring in the neonate will not be considered, because the etiologies and physiologic responses to gastrointestinal illness may be different. The emphasis, therefore, is on the patient with symptoms of diarrhea and/or vomiting who is between 1 month and 5 years of age and who has had the complaint for fewer than seven days.

PATIENT IDENTIFICATION

The age of the patient should always be recorded on the chart. In the child with gastroenteritis, age is an important consideration. Younger and smaller patients have increased metabolic rates as a result of their relatively large surface areas and so have increased fluid requirements. In addition, they may be less able to conserve fluid by not being able to concentrate the urine maximally. Gender and race should be entered on the patient’s chart even though these are not important considerations in the patient with diarrhea. The previous health of the patient is important information, as is the presence of any chronic medical problem. Drugs are sometimes indicated in the management of infants with gastroenteritis and it is essential that any known drug allergies be noted prominently on the medical record.

HISTORY

Vomiting and diarrhea are the cardinal symptoms of acute gastroenteritis. It is important that they be described accurately, particularly with respect to duration and frequency. The type of stool should be recorded, including its consistency and the presence of blood or mucus. The quantity of stool may be difficult to estimate, particularly with the use of highly absorbent diapers, but stool amount and frequency provide important indicators of the risk of dehydration. The type of onset may provide a clue to etiology. Very abrupt onset is characteristic of several of the bacterial dysenteries, although rotavirus infection may also begin quite abruptly. The presence of vomiting along with the diarrhea may also provide a clue to etiology. It is more characteristic of rotavirus and Norwalk virus infections than of
Diarrhea
Type of onset, eg, abrupt
Duration of diarrhea
Description of stool
Vomiting
Duration and frequency of vomiting
Fever
Food and fluid intake
Medicines
Urine frequency/volume

some of the other common causes of diarrhea. Although some patients may have vomiting as an isolated symptom, one should not make the diagnosis of gastroenteritis in a patient who does not also have diarrhea. The importance of vomiting is that it restricts intake. When vomiting appears early in the illness, hypernatremia is likely in patients younger than 1 year of age. Many other acute systemic problems (eg, streptococcal pharyngitis in 4- to 5-year-old patients) should be considered in that clinical circumstance, along with the possibility of central nervous system disease, renal disease, or poisoning. Abdominal pain is also a frequent symptom of gastroenteritis. If present, a description of its time of onset, its apparent severity, and its location and duration is important, as is some notation regarding whether it is intermittently cramping or constant.

The presence or absence of fever should be recorded. A body temperature greater than 39 to 40°C may be found in the presence of viral or bacterial infection, and increases the rate of insensible fluid loss and the need for fluid replacement. Because dehydration is the major immediate concern, the amount and type of food and fluids ingested since the onset of illness should be noted, as should the urinary output, although the latter may be difficult to determine in the young infant. The type and amount of oral fluid given during the last 12 hours should be noted in detail if dehydration is present. In this setting, documented weight loss indicates dehydration and/or poor nutrition. The occurrence of a seizure may provide a clue to Shigella infection; in some patients with gastroenteritis, seizures may indicate hypernatremic dehydration or its converse, severe hyponatremia. The type and amount of any medications given for the diarrhea should be recorded, as should the ingestion of any other medications, particularly antibiotics, that may be responsible for gastrointestinal symptoms. Determining the etiology of the illness may be assisted by identifying a potential source of infection, such as other members of the family with similar illnesses, the presence of similar illness in the community, exposure to pets, attendance at a day care facility, travel to foreign countries, or ingestion of food or water from unusual sources, as may occur during a camping trip.

PHYSICAL EXAMINATION

A thorough physical examination should be done on all patients with vomiting and diarrhea because infections elsewhere than in the gastrointestinal tract may be responsible for the symptoms, or associated with the illness. For example, otitis media may be present in a young infant whose major symptoms seem to be gastrointestinal in origin. A description of the overall appearance of the patient is important. An alert, active, and playful child is unlikely to be seriously ill or to be dehydrated, whereas the absence of these characteristics may provide an important clue to the seriousness of the illness. The drowsy or comatose patient is probably severely dehydrated. For the reasons cited above, the body temperature, pulse rate, and respiratory rate may be helpful. A rapid pulse of low volume indicates the possibility of dehydration; respiratory changes may provide a clue to the presence of metabolic acidosis or alkalosis. In the presence of acidosis, respirations may be deep and more rapid than usual. If the patient appears clinically dehydrated, or has manifestations of poor circulation such as poor capillary refill, the blood pressure should be recorded. It is essential that the weight be documented to determine whether any weight loss has occurred, to provide a basis for future comparison, and to calculate maintenance and replacement fluids. A recent length or height should also be present on the chart. Careful attention should be paid to the possibility of dehydration, which will be manifested by diminished tearing, dry mucous membranes, reduced skin turgor, and reduced urine output. If dehydration is present,
a statement about whether it is mild, moderate, or severe is appropriate. However, hypernatremia may mask the severity of dehydration because of the “doughy” feel of the skin. The results of the abdominal examination should be noted, with particular attention to the presence of abdominal distention, tenderness, masses, or enlarged organs, and the presence or absence of peristalsis. Results of a rectal examination should be recorded if the abdomen is distended, if peristalsis is absent, or if masses are identified. Rectal examination may also be helpful by stimulating a stool for inspection and study.

LABORATORY STUDIES

Although stool cultures need not be done in every patient with acute gastroenteritis, the result of stool culture should be recorded in patients who have the abrupt onset of severe diarrhea, particularly if mucus, blood, or leukocytes are present, if the patient is febrile and appears seriously ill, or if the symptoms persist or recur. If the clinical symptoms are compatible with a bacterial illness, the record should reflect that a fresh stool was examined for leukocytes, the presence of >5 leukocytes/hpf markedly increases the chances that the illness is bacterial in origin. An early culture is also worthwhile in epidemiologic circumstances that make bacterial illness likely. Studies for ova and parasites should be done if the symptoms persist longer than seven days, if the child attends a day care center where giardiasis is frequently encountered, or if the child has been drinking water that has not been properly chlorinated. Viral studies, as for rotavirus, are of limited use clinically because the findings will not change management, but may be helpful from an epidemiologic standpoint.

In the child who appears acutely ill, the results of a leukocyte and differential cell count may be helpful. For example, an increase in the leukocyte count, especially increased band forms, is a clue to the possible presence of shigellosis. The results of blood cultures should be recorded in the febrile, ill-appearing infant with suspected bacterial disease. Serum electrolyte, bicarbonate, and urea nitrogen measurements should be recorded if the child is clinically dehydrated or has lost a significant amount of weight. If diarrhea persists or recurs with reinitiation of feeding, stool pH and the presence of reducing substances or glucose should be noted as indicators of sufficient intestinal damage to result in disaccharidase (especially lactase) deficiency.

TREATMENT

Most patients with acute gastroenteritis can be managed as outpatients. However, patients with serious dehydration, shock (capillary filling time >3 sec), or a toxic appearance should be hospitalized. In most such patients, parenteral fluid therapy is indicated but that clinical problem will not be further considered here.

In the child with mild diarrhea, there may be little reason for specific treatment. Infants who are breast fed can continue to nurse, and those who are formula fed often will tolerate feeding well. In either instance, provision of extra fluid in the form of a maintenance oral electrolyte solution should prevent any significant ill effects from fluid losses.
In patients who have more acute or severe symptoms, temporarily discontinuing regular feedings for a relatively brief period of time may be helpful. Hydration should be maintained with a maintenance type of oral electrolyte solution. If clinical dehydration is present, the estimated losses should be replaced initially with an appropriate solution of higher electrolyte content.\(^{11-13}\) As soon as practical, and certainly within 24 hours, a lactose-free formula, a diluted standard formula, or breast feeding may be resumed.\(^{14-17}\) As soon as tolerated, small amounts of easily digested foods such as rice cereal may be given. Although infants and children who are fed during the course of acute gastroenteritis may experience increased stool losses, these can usually be compensated for by the provision of extra fluids orally; maintenance of nutrition may be beneficial in the long term.\(^{10}\) A notation of the specific dietary therapy and a notation that specific instructions were provided about reinstitution of feeding should be made on the patient’s chart.

A special problem is the infant with significant vomiting, particularly if it is the primary clinical manifestation, as may occur at the onset of disease. A brief period (two to four hours) of withholding all foods and fluids may be helpful in such patients. Feeding with a commercial maintenance solution can then be instituted, with small amounts to be given frequently. The period of fasting should not be so prolonged that the risk of dehydration is increased.

In any of these clinical circumstances, it is essential that careful instructions be provided to the child’s caretaker. Those instructions should be documented on the patient’s chart. Particularly to be avoided are casual instructions for “clear fluids” which can be nonphysiologic and harmful if they contain no electrolytes, excessive amounts of electrolytes or sugar, or are given in unrestricted amounts that may actually increase the amount of diarrhea. Commercially available electrolyte solutions are preferable to “home-made” solutions because the amounts of electrolytes are standardized and the carbohydrate content is appropriate to ensure maximum absorption of sodium and water. Rice-based oral rehydration solutions have also been shown to be effective in correcting the fluid losses associated with acute gastroenteritis.\(^{18}\) Both hyponatremia and hypernatremia may be avoided by attention to these details. In any case, fluid intake must exceed stool losses. This should be assured by frequent contact either during a return visit or by telephone reports that weight and urinary output are being maintained, that intake is adequate, and that stool losses are decreasing. It is important to record the patient’s progress in the record. If the oral electrolyte solutions are not being accepted well, as is occasionally the case in toddlers, mixing a replacement solution with fruit juice (other than apple or pear juice), or with one of the commercially available solutions designed for athletes, may be acceptable. The latter are usually not ideal as primary sources of fluid and electrolytes because the sugar content may be sufficiently high to aggravate an osmotic diarrhea, and the amount of electrolytes may be inadequate to keep up with continuing losses.

Most infantile diarrhea does not require antimicrobial therapy. However, enteritis caused by specific organisms may require specific drug therapy. The drug selected, the dosage, and duration of therapy should be recorded. The recommendations for salmonellosis depend upon the age of the patient and the clinical illness. Infants are at greater risk for bacteremia and nonintestinal infections and should be treated as currently recommended. The older patient is often beginning to recover by the time the culture is known to have grown \textit{Salmonella}. Such patients or asymptomatic carriers should not be treated because the organism is often not eradicated and the carrier state may be perpetuated. It often takes weeks or months for \textit{Salmonella} to be eradicated from the stool of young patients, even though they are asymptomatic.

Giardiasis is one of the common intestinal infections of infants and toddlers who attend day care centers, but again requires treatment only if affected patients are symptomatic.
However, eradication of the organism with specific therapy may help prevent its spread from asymptomatic carriers to uninfected children in day care centers or institutions, and to other family members.19

Antiemetic drugs are of questionable value in patients who are vomiting and may have undesirable side effects. Prochlorperazine is specifically contraindicated because of the risk of extrapyramidal symptoms. Promethazine is not approved for use in children younger than 2 years of age. Trimethobenzamide is not recommended for treatment of uncomplicated vomiting. The sedative effect of these centrally active antiemetic drugs may confuse the clinical evaluation of children with acute illness, and have the potential for masking the symptoms of more serious underlying disease.

In general, antidiarrheal drugs are ineffective and should be used with caution, particularly in infants.19 Drugs that interfere with intestinal motility may result in fluid retention in the intestine, which may further aggravate dehydration and electrolyte imbalance. Such drugs include loperamide, diphenoxylate, and atropine. Loperamide and diphenoxylate are not recommended for use in children younger than 2 years of age. “Absorbent” substances such as kaolin and pectin have no proven value in the management of diarrhea.

Certain of the specific bacterial enteritides are of public health importance and must be reported to the proper authorities. All pathogens of infectious diarrhea are transmitted readily from person to person. Careful hand washing after handling soiled diapers is the most effective way of preventing such spread.9

FOLLOW-UP EVALUATION

Daily visits or telephone contacts should be documented in the chart to insure that complications are avoided or identified promptly. If specific pathogens are identified, follow-up cultures or examinations are warranted. In patients who have persistence (more than one to two weeks) or repeated recurrence of diarrhea, causes other than simple gastroenteritis should be pursued. The most important goal of immediate and follow-up care is the maintenance of nutrition and of adequate hydration.

EDUCATION

Parents and other caretakers need to be aware of the dangers of prolonged vomiting and severe diarrhea and of the symptoms and signs of dehydration. They may need encouragement to comply with dietary recommendations, particularly if the patient is a toddler and demanding to be fed. Parents also need to be aware of how to dispose of soiled diapers, the importance of hand washing in preventing spread of infection, and the need for isolation from day care or school contacts until the period of infectivity has passed.
## Conversion Table to Standard International (SI) Units

### I. Hematology

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Conversion Factor</th>
<th>SI Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin g/dL</td>
<td>x 0.155</td>
<td>mmol/L</td>
</tr>
<tr>
<td>Platelets/mm³</td>
<td></td>
<td>count/µL = 10⁶ cells/L</td>
</tr>
<tr>
<td>Leukocytes/mm³</td>
<td></td>
<td>count/µL = 10⁶ cells/L</td>
</tr>
<tr>
<td>Erythrocytes/mm³</td>
<td></td>
<td>count/µL = 10⁶ cells/L</td>
</tr>
<tr>
<td>Hematocrit % x 0.01</td>
<td></td>
<td>vol RBC/vol whole blood</td>
</tr>
<tr>
<td>Reticulocytes % x 0.01</td>
<td></td>
<td>(1)</td>
</tr>
</tbody>
</table>

### II. Blood Pressure

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Conversion Factor</th>
<th>SI Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm Hg (torr) x 1.333</td>
<td></td>
<td>mbar</td>
</tr>
</tbody>
</table>

### III. Blood Gases

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Conversion Factor</th>
<th>SI Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCO₂ mm Hg x 0.1333</td>
<td></td>
<td>kPa</td>
</tr>
<tr>
<td>PO₂ mm Hg x 0.1333</td>
<td></td>
<td>kPa</td>
</tr>
<tr>
<td>Base excess mEq/L = mmol/L</td>
<td></td>
<td>mmol/L</td>
</tr>
<tr>
<td>pH value = same</td>
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<td></td>
</tr>
</tbody>
</table>

### IV. Blood Chemistries

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Conversion Factor</th>
<th>SI Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetone mg/dL x 0.1722</td>
<td></td>
<td>mmol/L</td>
</tr>
<tr>
<td>Acetaminophen µg/mL x 6.62</td>
<td></td>
<td>µmol/L</td>
</tr>
<tr>
<td>Albumin g/dL x 144.9 or g/L x 14.49</td>
<td></td>
<td>µmol/L</td>
</tr>
<tr>
<td>Aldosterone ng/dL x 0.0277</td>
<td></td>
<td>nmol/L</td>
</tr>
<tr>
<td>Ammonia mgN/dL x 0.714</td>
<td></td>
<td>mmol/L</td>
</tr>
<tr>
<td>Bicarbonate mEq/L</td>
<td></td>
<td>mmol/L</td>
</tr>
<tr>
<td>Bilirubin mg/dL x 17.10</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Blood urea nitrogen mg/dL x 0.357</td>
<td></td>
<td>mmol urea/L</td>
</tr>
<tr>
<td>Calcium mg/dL x 0.25</td>
<td></td>
<td>mmol/L</td>
</tr>
<tr>
<td>Carotene IU x 0.6</td>
<td>µg</td>
<td>µg/L</td>
</tr>
<tr>
<td>or µg/dL x 0.01863</td>
<td></td>
<td>µg/L</td>
</tr>
<tr>
<td>Ceruloplasmin mg/dL x 0.0662</td>
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<td>µmol/L</td>
</tr>
<tr>
<td>Chloride mEq/L</td>
<td></td>
<td>mmol/L</td>
</tr>
<tr>
<td>Cholesterol mg/dL x 0.0259</td>
<td></td>
<td>mmol/L</td>
</tr>
<tr>
<td>Complement component (C3) mg/dL x 0.01</td>
<td></td>
<td>g/L</td>
</tr>
<tr>
<td>Copper µg/dL x 0.157</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Cortisol µg/dL x 27.59</td>
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<td>nmol/L</td>
</tr>
<tr>
<td>Creatine mg/dL x 76.26</td>
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</tr>
<tr>
<td>Creatinine mg/dL x 88.40</td>
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<td></td>
</tr>
<tr>
<td>Digoxin ng/mL x 1.28</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Enzymes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alanine aminotransferase (ALT, SGPT) U/L</td>
<td></td>
<td>U/L</td>
</tr>
<tr>
<td>Aldolase</td>
<td>U/L</td>
<td></td>
</tr>
<tr>
<td>Sibley-Lehninger units/mL</td>
<td>U/L</td>
<td></td>
</tr>
<tr>
<td>Amylase</td>
<td>U/L</td>
<td></td>
</tr>
<tr>
<td>Somogyi units/dL</td>
<td>U/L</td>
<td></td>
</tr>
<tr>
<td>Aspartate aminotransferase (AST, SGOT) U/L</td>
<td></td>
<td>U/L</td>
</tr>
<tr>
<td>Creatine kinase (CK) U/L</td>
<td>U/L</td>
<td></td>
</tr>
<tr>
<td>Phosphatase</td>
<td>U/L</td>
<td></td>
</tr>
<tr>
<td>Bodansky units/dL</td>
<td>U/L</td>
<td></td>
</tr>
<tr>
<td>King-Armstrong units/dL</td>
<td>U/L</td>
<td></td>
</tr>
<tr>
<td>Substance</td>
<td>Unit</td>
<td>Conversion Factor</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Fatty acids mg/dL x 0.0354</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Ferritin ng/mL x 1</td>
<td>µg/L</td>
<td></td>
</tr>
<tr>
<td>α₁-Fetoprotein ng/mL x 1</td>
<td>µg/L</td>
<td></td>
</tr>
<tr>
<td>Fibrinogen mg/dL x 0.01</td>
<td>g/L</td>
<td></td>
</tr>
<tr>
<td>Folic acid µg/dL x 22.65</td>
<td>nmol/L</td>
<td></td>
</tr>
<tr>
<td>Glucose mg/dL x 0.0055</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Glycerol mg/dL x 0.1086</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Haptoglobin mg/dL x 0.01176</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>17-Hydroxycorticosteroids mg/d x 2.759</td>
<td>µmol/d</td>
<td></td>
</tr>
<tr>
<td>Insulin IU x 0.04167</td>
<td>mg</td>
<td></td>
</tr>
<tr>
<td>or µU/mL x 1.0</td>
<td>mU/L</td>
<td></td>
</tr>
<tr>
<td>Iodine µg/dL x 78.8</td>
<td>nmol/L</td>
<td></td>
</tr>
<tr>
<td>Iron µg/dL x 0.1791</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Iron binding capacity µg/dL x 0.1791</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>17-Ketosteroids mg/d x 3.467</td>
<td>µmol/d</td>
<td></td>
</tr>
<tr>
<td>Lead µg/dL x 0.0483</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Lipoprotein mg/dL x 0.01</td>
<td>g/L</td>
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</tr>
<tr>
<td>Magnesium mg/dL x 0.4114</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>or mEq/L x 0.5</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Phosphorus mg/dL x 0.3229</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Potassium mEq/L</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Prednisone mg x 2.79</td>
<td>µmol</td>
<td></td>
</tr>
<tr>
<td>Protein g/dL x 10</td>
<td>g/L</td>
<td></td>
</tr>
<tr>
<td>Salicylate mg/dL x 0.0724</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Sodium mEq/L</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Theophylline µg/mL x 5.55</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Thyroid-stimulating hormone µU/mL x 1</td>
<td>mU/L</td>
<td></td>
</tr>
<tr>
<td>Thyroxine µg/dL x 12.87</td>
<td>nmol/L</td>
<td></td>
</tr>
<tr>
<td>Transferrin mg/dL x 0.01</td>
<td>g/L</td>
<td></td>
</tr>
<tr>
<td>Triglycerides mg/dL x 0.01</td>
<td>g/L</td>
<td></td>
</tr>
<tr>
<td>Triiodothyronine ng/dL x 0.0154</td>
<td>nmol/L</td>
<td></td>
</tr>
<tr>
<td>Urea nitrogen mg/dL x 0.357</td>
<td>mmol urea/L</td>
<td></td>
</tr>
<tr>
<td>Uric acid mg/dL x 59.48</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Vitamin A µg/dL x 0.0349</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Vitamin B₆ pg/dL x 0.738</td>
<td>pmol/L</td>
<td></td>
</tr>
<tr>
<td>Vitamin C mg/dL x 56.78</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Vitamin E µg/dL x 2.322</td>
<td>µmol/L</td>
<td></td>
</tr>
<tr>
<td>Xylose mg/dL x 0.0667</td>
<td>mmol/L</td>
<td></td>
</tr>
<tr>
<td>Zinc µg/dL x 0.153</td>
<td>µmol/L</td>
<td></td>
</tr>
</tbody>
</table>

V. Urine or Stool
- Coproporphyrin µg x 1.53 - nmol
- Epinephrine µg/d x 5.458 - nmol/d
- Vanilmandelic acid mg/d x 5.046 - µmol/d
- Homovanillic acid mg/d x 5.489 - µmol/d

VI. Energy
- Kcal x 4.1868 - KJ (Kilojoule)
- Rad x 0.01 - Gy (Gray) (joule/kg)

VII. Radionuclide Activity
- Curie (Ci) x 37 - GGq (Gigabecquerel)
REFERENCES


NOTES