

Ten-minute consult: Why is my baby always crying?

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It is common for babies to cry. A 2017 systematic review identified that newborns cry about two hours a day, peaking to an average of three hours by six weeks age, eventually decreasing to one hour a day by age four months.

Mostly it has a benign underlying cause. In acute cases, it is prudent to rule out a medical cause. The presence of any red flags (e.g. decreased feeding, fever, vomiting, rash) should prompt urgent medical assessment. However, the majority will have a few weeks history of persistent, excessive crying, and the sleepless and distressed parents will present for help.

Is this colic?

Infantile colic is a symptom-based diagnosis following the 'rule of three' – excessive, inconsolable crying for at least three hours a day, for at least three days a week, for at least three weeks. It usually presents at the same time of the day, commonly late afternoons, and can start and stop quite abruptly.

Its incidence is reported to be as high as 40% of all infants, typically peaking at six weeks and resolving by six months of age. It is benign and self-limiting, and its etiology remains elusive.

Recent studies found that

Key messages

- Probiotic drops containing *L. reuteri* DSM 17938 can be used to treat colic in breastfed but not formula-fed babies
- Distinguish infant dyschesia from constipation, to avoid unnecessary use of laxatives
- In diagnostic uncertainty between GOR and CMPA, change formula before trialling PPIs. Lactose intolerance is uncommon in babies. Treat as CMPA if suspected.

administration of probiotic drops containing *L. reuteri* DSM 17938 significantly decreased colic in breastfed infants, but actually increased crying in bottle-fed babies. Simethicone, present in infant colic drops, is safe although a recent systematic study showed it is no better than placebo. Simple soothing techniques such as swaddling, skin-to skin contact, warm bath, massage etc and parental reassurance remain the mainstay of management.

What about constipation?

Constipation is far less common in babies than in older children, with notable peaks with any dietary changes (e.g. changing formula,

weaning onto solids). Stooling can be as frequent as with every feed or as infrequent as a couple of times a week, depending on the age and other factors. Hence stooling frequency is not a reliable indicator for infant constipation.

However, consistently painful bowel movements with hard pellet like stools can be safely treated with easily available Poloxamer based osmotic laxatives that can be administered as drops. Lactulose is an alternative but can have side effects such as flatulence and abdominal cramps, and a plateauing effect with higher doses. Extra water (boiled and cooled) may be safely given.

Infant dyschesia

Dyschesia is often mistreated as constipation, and its recognition by health-care professionals remains suboptimal. It is defined (Rome IV) as straining and crying for at least 10 minutes, often associated with infants turning red or purple in the face, before successful passage of soft stools.

It is thought to be due to in-coordination between increased intra-abdominal pressure preceding defecation and relaxation of the pelvic floor muscles. It usually starts in the first months of life and resolves spontaneously after a few weeks, and always characterised by passage of soft stools. Parental reassurance is the key, and laxatives avoided.

Reflux or milk allergy?

Gastro-oesophageal reflux (GOR) and cow's milk protein allergy (CMPA) are relatively common in the first year of life, presenting with symptoms such as food refusal, irritability, vomiting, crying, back arching, poor appetite, slow weight gain and sleep disturbances. That both conditions have similar symptoms, coupled with no reliable diagnostic tests, makes the diagnosis challenging. Blood and/or



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mucous in stool, chronic diarrhoea or atopic risk factors makes CMPA more likely.

Where there is diagnostic uncertainty, the current recommendation is to change formula before acid suppression.

The recommended formula change is to an *extensively* hydrolysed formula (eHF), hydrolysed rice formula (HRF) or amino acid based formula (AAF), there is no role for hydrolysed formula only, and soy milk is not recommended due to cross-reactivity. If mother is keen to breast feed, a strict maternal dairy and soy free diet is

recommended. Acid suppression with proton pump inhibitors (PPIs) are safe and effective in babies, and a trial of 6-8 weeks is prudent if there is a suboptimal response to formula change. Refractory cases warrant referral to a paediatrician or paediatric gastroenterologist.

Lactose intolerance?

Although not all reactions to cow's milk are due to CMPA, lactose intolerance is uncommon in babies. If symptomatic, babies should be treated as CMPA. This is because lactose intolerance only manifests later in life with the gradual decline in production of the enzyme lactase.

However, some babies can be born

with congenital lactase deficiency, and they present since birth with profuse diarrhoea and failure to thrive. If strongly suspected, it is usually transient, and breastfeeding should be continued. If formula fed, a change to a lactose free formula can be trialled, with resolution of symptoms within 2-3 days (as opposed to CMPA wherein it can take 4-6 weeks for symptoms to resolve). **mf**

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