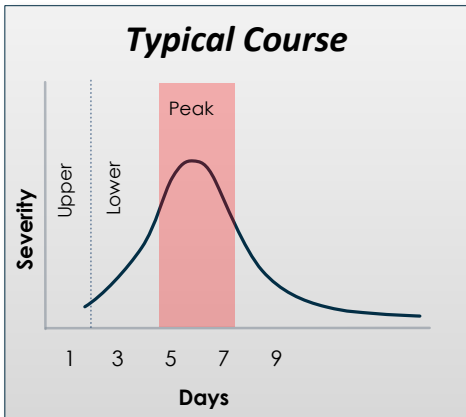




MANAGEMENT OF Bronchiolitis

This EPPA Clinical Guideline is intended to guide most, but not all, encounters involving bronchiolitis and should not replace clinical judgment; deviate from or adapt this guideline to meet the individual patient's needs.



Definitions
Diagnosis: Prodrome of rhinorrhea followed by cough, tachypnea, wheezing, rales and increased respiratory effort manifested as grunting, nasal flaring, and intercostal and/or subcostal reactions.
Population: Age < 2 years.

History of the following?

- Immunodeficiency.
- Recurrent wheezing.
- Chronic neonatal lung disease.
- Neuromuscular disease.
- Cystic fibrosis.
- Hemodynamically significant congenital heart disease.

Excluded from guideline. Use clinical judgment.

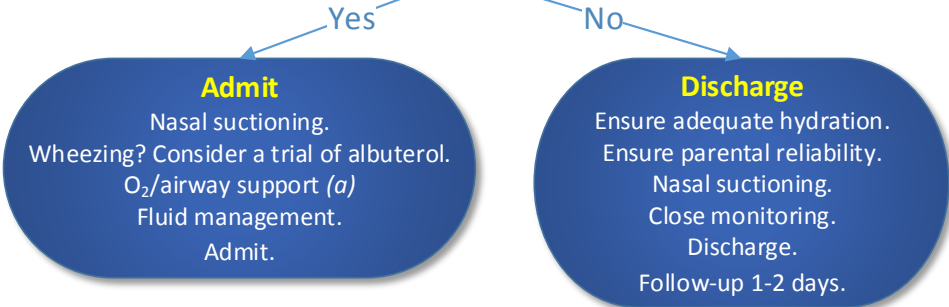
O₂/Airway Support (a)
 O₂ to maintain SpO₂ ≥ 90%
 ↓
 HFNC[†] and/or CPAP
 ↓
 Intubation

HFNC
 (Heated, humidified, high-flow nasal cannula)

- Requires special device (e.g. Vapotherm, Comfort Flo, Optiflow)
- 4-8 L /minute
- Site dependent, call respiratory therapy.

Severe Bronchiolitis? Any of the following:

- Based on frequent reassessments.
- Toxic appearance, poor feeding, lethargy, dehydration.
- Moderate to severe respiratory distress: nasal flaring, retractions, RR > 70, cyanosis.
- Apnea.
- Hypoxemia (generally SpO₂ < 90%).





MANAGEMENT OF Bronchiolitis

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Key Points:

Pearls

- **Season:** December – March
- **Scoring:** No widely accepted scoring system.
- **Labs:** Routine RSV testing only if patient is receiving RSV prophylaxis. Influenza testing per protocol.
- **Imaging:** CXR only if patient requires ICU or clinical evidence of airway complication (e.g. pneumothorax).
- **Typical Course:** Upper respiratory symptoms on day 1, lower respiratory symptoms starting days 2-3, peak days 5-7 then gradually resolve.

Therapies not routinely recommended (level of evidence; strength of recommendation)

- Bronchodilators (B; strong)[†]
- Nebulized hypertonic saline in ED (B; moderate)[§]
- Steroids (A; strong)
- Epinephrine (B; strong)
- Antibiotics in the absence of bacterial infection (B; strong)
- No good evidence on deep suctioning

[†]Generally excludes patients with history of recurrent wheezing and patients with severe disease.

[§]May be trialed in hospitalized patients, but has not been shown to decrease need for hospitalization.

Nasal Suction Tips

- Place the infant on back. Place 1-2 drops of saline in each nostril. Wait a short period. Saline drops may be purchased or made at home (1/4 teaspoon salt in 8 ounces warm water). Solution may be stored (covered) for up to 1 week.
- Use bulb suction or nasal aspirator (NoseFrida).
- Perform 1-3 times per day as needed.
- Best before feeding (process may cause vomiting if performed after).
- More information can be found at:

<http://www.cincinnatichildrens.org/health/s/suction>

Follow-Up Resources:

- **Primary Care**