Acute bronchiolitis

Epidemiology

RSV infection in ¾ seasonal
IP 2-8 days

May develop post-bronchiolitis wheeze

History

- breathing difficulty /cough / poor feeding
- fever
- audible wheeze
- in very young may have apnoea

Examination

- fast respiratory rate
- use of accessory muscles of respiration
- audible wheeze
- pallor, head bobbing
- apnoeic spells

Pattern of illness

- Prior coryza x 2/7
- Peaks at 72 hours
- If fever> 39 degrees think of other causes

Hospital referral

History of apnoea
Resp rate > 60
Grunting or nasal flaring
cyanosis
Severe recession
Feeding < 50%
Saturations < 94%
Uncertainty re diagnosis

Hospital Investigations

- NPA for RSV
- CXR only if severe
- pulse oximetry

Risk factors for severe disease

Preterm < 32 weeks
Congenital H disease
Chronic lung disease
immunodeficiency
Downs
Severe hypotonia

Treatment

- maintain hydration – may need NG feeds
- oxygen via nasal prongs
- Hypertonic saline
- no role for antibiotics/steroids / inhalers in primary care

References

- SIGN CG 91 Bronchiolitis in children 2006

TAKE HOME MESSAGES

Very common illness

Treatment supportive

May wheeze for 4/52 post-illness

Is highly infectious

Evidence base

Inhaled /po steroids / chest physio / beta 2 agonists / nebulized adrenaline all not recommended (A)

This algorithm has been produced by the National Paediatric and Neonatology Clinical Programmes. It is aimed at medical, nursing and allied health professionals working in both primary and emergency care settings.

Suggestions of QIP committee of ICGP incorporated – PINKcolour denoted secondary care treatment

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