**BRONCHIOLITIS **

Young child (typically <1year, but seen up to 2 years, peak age 6 months) presents with:

URTI - after 2-3 days progressing to:

* Poor feeding • wheeze
* Increasing cough/vomiting
* Increased respiratory effort • mild pyrexia rarely >39 deg
* Exhaustion • widespread fine crepitations
* Apnoea (<4months) • hyper inflated chest
* Sub costal, intercostal recessions, tracheal tug, head bobbing
* De-saturations ● tachypnoea

Peak severity around 3-5 days of illness, gradual recovery over next 8-10 days

Does baby have any increased risk?

* Preterm or low birth weight
* Age < 3 months (**esp<6/52**)
* Chronic lung disease or pre -existing oxygen dependence
* Congenital heart disease
* Cystic fibrosis
* Severe immunodeficiency
* Pulmonary hypertension
* Adenovirus bronchiolitis
* Neuromuscular disorders

Refer to paediatrics

**if severe symptoms below**

* Move to resus /HDU
* Seek senior help in ED

 YES

|  |  |  |  |
| --- | --- | --- | --- |
| SYMPTOM | MILD | MODERATE | SEVERE |
| WORK OF BREATHING | Normal or mild subcostal recession | Raised respiratory and heart rates, intercostal recession, use of accessory musclesRR >60 | As moderate + grunting, head bobbing, sub costal recession, tracheal tug or nasal flaring, recurrent apnoea with or without bradycardiaRR >70 |
| SPo2 | >92% in air, including when sleeping | <92% in air | <92% in >50% O2 |
| OXYGEN NEEDED | none | O2 to maintain SpO2 >92% | As above |
| FEEDING | normal | Less than usual but >50% of normal volumeClinical dehydration | Not interested or <50% of normal volume |
| BEHAVIOUR | normal | Some intermittent irritability | Altered consciousness, fatigue, central cyanosis |

 NO

Assess severity of illness

 YES YES YES

**Discharge home with CCNT referral** (if very well 72 hours CCNT open access)

**Bronchiolitis advice leaflet**

**Advise parents**:

* Feed small amounts often
* May need to return if signs of worsening, describe red flags
* Cough and wheeze may persist for several weeks for which no treatment is helpful
* Refrain from smoking
* Re-infection may occur
* 50% of children may wheeze with future URTI
* Consider social circumstances, distance from healthcare and skill & confidence of the carer
* Bulb nasal suction may help with secretions for feeding

**Minimal handling**

**Infection control precautions**

**Maintain clear airway**,

* suction only if necessary
* consider 0.9%saline drops if nasal blockage

**O2 via nasal specs to maintain**

**SpO2 92-96%**

**Reduce feeds/consider NGT**

60-75% of normal 1-2 hourly

**Consider** nebulised 3% hypertonic saline x 4ml

**Consider** nebulised atrovent 125 to 250mcg or salbutamol 2.5mg if very wheezy, discontinue if no improvement

**Monitor closely**

**If fever >38.5 consider septic screen**

**Refer to Paediatric O&A** for longer period of observation

**Move to HDU/RESUS**

**Get ED senior help**

**Bleep Paeds Reg 7405**

**Maintain clear airway**,

* suction only if necessary
* use 0.9%saline drops if nasally blocked

**High flow O2 to maintain SpO2 92-96%**

**Insert OG/NG tube** on free drainage

**NBM - IV fluids,** 2/3maintenance avoiding hypotonic fluids

**Continuous monitoring**

**Capillary blood gas / U&E**

**Consider CPAP/ventilation** (under paeds guidance)

If fever >38.5 consider septic screen

**D/w NWTS**

**Notes:**

* Clinically assess hydration status
* **Do not** routinely perform blood tests, including capillary gas (unless worsening condition)
* **Do not** routinely perform a chest x ray
* **Do not routinely use:** antibiotics, hypertonic saline, adrenaline (nebulised), salbutamol, montelukast, ipratroprium bromide, systemic or inhaled corticteroids (or any combination of nebulised drugs)
* **Do not** routinely perform nasal suction (consider if respiratory distress of feeding difficulties due to upper airway secretions, use suction if apnoeic regardless of secretions)

For further guidance see Bedside Partnership Guidelines on Intranet or **NICE Guidance 9 Bronchiolitis in children**; diagnosis & management (2015), or refer to NWTS (guideline)