

Practical Pearl: Bronchiolitis

INTRODUCTION	<ul style="list-style-type: none"> • Leading cause of hospitalization for infants <1 year of age • Typically diagnosed in children <24 months of age • Respiratory syncytial virus (RSV) is the most common cause, accounting for 50-80% of cases • Respiratory distress results from airway obstruction, atelectasis, and wheezing/bronchospasm in some patients • http://pediatrics.aappublications.org/content/early/2014/10/21/peds.2014-2742
INITIAL EVALUATION AND MANAGEMENT BY PRIMARY CARE	<p>Evaluation</p> <ul style="list-style-type: none"> • HX: rhinitis and cough leading to increasing respiratory distress • PE: crackles, wheezes or both (the “washing machine” sound) • Poor intake and respiratory distress in more severe cases • Chest radiographs not needed for typical presentation • RSV testing not routinely needed, as it does not change treatment <p>Management</p> <ul style="list-style-type: none"> • Mild cases: supportive care only (oral hydration, nasal suction/ aspiration, acetaminophen as needed) • NO benefit from albuterol, epinephrine, corticosteroids, humidification, antibiotics, chest physiotherapy, mucolytics
WHEN TO REFER / HOSPITALIZE	<ul style="list-style-type: none"> • Poor oral intake / dehydration • Witnessed apnea • Respiratory distress / persistently increased work of breathing • Hypoxia • Close follow-up if age <12 weeks, history of prematurity, underlying chronic cardiopulmonary disease or immunodeficiency
HOW TO REFER	<ul style="list-style-type: none"> • Infants/children in respiratory distress should be referred to the ED for stabilization prior to admission • Otherwise, call (413) 794-KIDS • If you have questions, call Baystate Children’s Hospital at (413) 794-0000 and ask for the Pediatric Hospitalist On-Call
WHAT TO EXPECT FROM BAYSTATE CHILDREN’S HOSPITAL VISIT	<ul style="list-style-type: none"> • Assessment for other potential causes of difficulty breathing • Intravenous hydration if needed • Supplemental oxygen (simple nasal cannula or high flow nasal cannula) if oxygen saturation <90% or observed respiratory distress • Nasal and deep suctioning of secretions if needed • Evaluation by pediatric intensive care service if requiring higher levels of respiratory support needed