

Annex 2 Management of Bronchiolitis in General Practice

DIAGNOSIS

Bronchiolitis is likely if a child aged <18 months presents with:

- Initial signs and symptoms of an upper respiratory tract infection
- Cough
- Tachypnoea
- Inspiratory crepitations
- Wheeze

The diagnosis of bronchiolitis is clinical. Chest x-rays and virologic tests should NOT be used to diagnose bronchiolitis.

Consider alternate diagnoses in a child who presents with:

- Recurrent wheezing
- Cough as the predominant symptom
- Persistent, or repeated and prolonged, respiratory symptoms
- Failure to thrive
- Cardiac murmur, oedema or a history of slow onset of symptoms
- Sudden onset of symptoms, history of coughing/choking followed by expiratory wheeze, loss of voice, or differential air entry

Trial Of Bronchodilator Therapy

A child with bronchiolitis-like symptoms who responds to treatment with a bronchodilator is likely to have asthma.

Consider a trial of a single dose of β_2 agonist bronchodilators in patients older than 9 months, particularly with recurrent wheezing.

ASSESSMENT OF SEVERITY OF DISEASE*

Mild	Moderate	Severe	Life Threatening
<ul style="list-style-type: none"> • Normal respiratory rate • No or subtle accessory muscle use • Normal heart rate • Able to feed • <i>Oxygen saturation >95%*</i> 	<ul style="list-style-type: none"> • Increased respiratory rate • Minor accessory muscle use • Increased heart rate • Difficulty feeding • Minor dehydration • Crepitations • <i>Oxygen saturation 90-95%*</i> 	<ul style="list-style-type: none"> • Markedly increased respiratory rate • Moderate/marked accessory muscle use • Nasal flare and/or grunting • Markedly increased heart rate • Unable to feed • Marked dehydration • Toxic appearance • Sweaty • Irritable • <i>Oxygen saturation <90%*</i> 	<ul style="list-style-type: none"> • Cyanosis • Poor respiratory effort • Maximal accessory muscle use/exhaustion • Apnoeas

Take special care with children <3 months old or born at <36 weeks gestation, and those who have underlying cardiorespiratory disease as they have an increased risk of more severe disease and apnoea. Consider virologic testing to guide management in young febrile infants.

INITIAL TREATMENT

	SEND TO HOSPITAL BY AMBULANCE	SEND TO HOSPITAL BY AMBULANCE
<ul style="list-style-type: none"> • Encourage small frequent feeds • If nasal congestion, trial saline nasal drops • Provide patient information, including reasons to return • Arrange review in next 2 days • Send home if stable 	<ul style="list-style-type: none"> • Send to hospital if requiring oxygen • Consider sending to hospital if not tolerating oral feeds • Consider oxygen if child is <3 months old, has increased work of breathing, decreased oxygenation during feeds or saturation 90-92% • Encourage small frequent feeds • If nasal congestion, trial saline nasal drops • Provide patient information, including reasons to return • Arrange review in next 2 days • Send home if stable 	<ul style="list-style-type: none"> • Provide oxygen • Stay with the patient until the ambulance arrives • Send written assessment and referral details

***N.B. If patient has signs or symptoms across categories, always treat according to their most severe features.**

Oxygen saturation is an indicator of severity however it is recognised that this form of assessment will not be available to most GPs. Treatment should not be based on a child's oxygen saturation alone.