Management of Bronchiolitis in Primary Care

Common:

- Primarily in children under 2
- Affect 1 in 5 under 1y each year – with peak incidence between 3m-6m of age
- 3% require hospitalization

Typical features

- Wheeze and/or crackles throughout chest
- Prodromal coryzal illness which goes onto cough and increased work of breathing
- Fever (only in 30% of cases and usually <39C)
- Symptoms typically peak at 3d-5d then start improving. Cough resolves within 3w in 90% of infants
- Under 6w apnoea may be only clinical symptom/sign

Differential diagnosis:

- Bacterial pneumonia (looking for focal chest signs and fever >39C)
- Viral wheeze or early onset asthma (usually older, recurrent and variable symptoms, no fever)

Assessment

- Measure 02 saturation in ALL infants with suspected bronchiolitis
- Assess hydration (capill refill, pulse rate)
- Assess respiratory distress (count respiratory rate, look for recession and nasal flair, grunting)

Referral

Immediate (999 referral)	Consider same day referral
• Apnoea (observed or reported) • Severe respiratory distress (grunting, marked recession, RR>70 breaths/min) • Central cyanosis • O2 saturation <92% on air	• RR >60 breaths/min • Feeding difficulty (<75% usual intake) • Clinical dehydration

But have lower threshhold for referral with risk for severe bronchiolitis:

- Chronic lung disease
- Congenital heart disease
- Age <3m
- Premature infants (especially <32w)
- Neuromuscular disorder
- Immunodeficiency
- TAKE INTO CONSIDERATION SOCIAL AND CONFIDENCE AND ABILITY OF CARERS TO SPOT DETERIORATION

Management

- Advise for most infants treatment is supportive and condition is self-limiting
- If safe to manage at home advise on red flags
  - Work of breathing becoming hard/exhaustion
  - Poor fluid intake (<75% normal or no wet nappies for 12h)
  - Apnoea or cyanosis
- If sats <92% on air give supplemental 02 whilst awaiting transfer to hospital