Y Grŵp Gweithredu ar Iechyd Anadlol
Respiratory Health Implementation Group
Iechyd Plant Child Health
GIG CYMRU NHS WALES

icst.info/all-wales-guideline-for-the-management-of-rsv-bronchiolitis/

Find out more from the National Paediatric Lead

All Wales Guideline for Hospital Management of Bronchiolitis

Initial Assessment
Emergency Department or Children's Assessment Unit

Mild
- Oxygen sats >92%
- Mild respiratory distress
- Feeds >75% normal
- Wet nappies

Moderate
- Oxygen sats >92%
- Moderate respiratory distress
- Feeds 50-75% normal
- Decreased wet nappies

Consider admission
- Early stage of illness
- Risk factors for severe disease
- Difficult social circumstances
- Low skills/ confidence in carer
- <4 weeks of age

Severe
- Oxygen sats ≤92%
- Severe respiratory distress
- Feeds <50% normal
- Lethargic and tiring
- Apnoeas

Apnoeas may be the only clinical sign of bronchiolitis in young infants. Always consider alternative diagnoses. **Apnoeas** respond well to pressure support. Escalation to CPAP rather than Hi-Flow.

Criteria for discharge from ED/CAU
- Oxygen sats >92% (awake and asleep)
- Completed at least 1 oral feed
- Oral intake >75% normal

Review after 2-4 hours observation

Discharge
When stable in air and feeding orally
- Explain diagnosis
- Refer to patient advice sheet
- Explain expected time course for disease
- Discuss red flags suggesting deterioration
- Address parental smoking
- Think "safeguarding"
- Consider follow-up to monitor disease progress in 24-48 hours (longer if early stage of illness)
- Consider hospital follow-up for those who received critical care

Criteria for discharge from WARD
- Oxygen sats >90% (awake and asleep)
- Completed at least 1 oral feed
- Oral intake ≥75% normal

Admit to Ward
Assessment on the Ward

Minimal handling
Consider **gentle nasal suction**

Oxygen therapy
- Start oxygen if saturations <92% in air
- Give as low flow oxygen (max 2L/min) via nasal cannulae
- Consider early use of Hi-flow therapy

Feeding plan
If signs of increased work of breathing
- Consider reducing volume and increasing frequency of each feed
- Aim for 50-75% of usual feed volume

Escalation to Hi-Flow
- If oxygen saturations <92% despite nasal flow rate ≥2L/min or signs of severe respiratory distress, change to hi-flow.
- Start Hi-Flow at 2L/kg/min

Inform Consultant

Escalation to tube feeds
If oral feeds <50% normal
- Consider orogastric or NG feeding
- Avoid oral feeds on Hi-flow therapy

De-escalation
Switch back to low flow oxygen as soon as oxygen saturations >90% in FiO_2 <30%

2 hour review

De-escalation

Escalation to CPAP
- If oxygen concentration >60% on Hi-Flow, or no improvement in work of breathing/ tachycardia despite Hi-Flow, consider trial of nasal CPAP.

Admit to HDU
Inform Consultant and Anaesthetist

Escalation to IV fluids
If poor tolerance of OG/NG feeds, or signs of severe respiratory distress
- Consider intravenous fluids (80% maintenance)
- Monitor U&Es at least once daily

Patient advice page and leaflet

Diagnosis
- Age <1 year
- A coryzal prodrome lasting 1 to 3 days
- Persistent cough
- Tachypnoea and/or chest recessions
- Crackles and/or wheeze

Children age 1-2 years may also contract RSV bronchiolitis and should be managed similarly to infants

Risk factors for severe disease
- Congenital heart disease
- Chronic lung disease
- Preterm (born <32 weeks gestation)
- Neuromuscular disorder
- Immunodeficiency

Low threshold for admission and individualised management plan

Evidence-based medicine
Do not administer
- Hypertonic saline
- Bronchodilators
- Anticholinergics
- Inhaled steroids
- Oral steroids
- Adrenaline
- Physiotherapy

Do not routinely carry out
- Intravenous access
- Blood tests
- Blood gas
- Chest x-ray

Indications: chest x-ray and/or antibiotics
- Haemodynamically unstable
- Persistent fever >39°C
- Protracted clinical course (>5 days)
- Consider if on CPAP

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