VCMC/SANTA PAULA HOSPITAL CLINICAL PRACTICE GUIDELINE
DIAGNOSIS OF BRONCHIOLITIS

The contents of this Clinical Practice Guidelines are to be used as a guide. Healthcare professionals should use sound clinical judgment and individualized patient care. This CPG is not meant to be a replacement for training, experience, CME or studying the latest literature and drug information.

Diagnosis

1. Clinicians should diagnose bronchiolitis and assess disease severity on the basis of history and physical examination.
2. Clinicians should assess risk factors for severe disease, such as age less than 12 weeks, a history of prematurity, underlying cardiopulmonary disease, or immunodeficiency, when making decisions about evaluation and management of children with bronchiolitis.
3. When clinicians diagnose bronchiolitis on the basis of history and physical examination, radiographic or laboratory studies should not be obtained routinely.

Treatment

1. Clinicians should not administer albuterol (or salbutamol) to infants and children with a diagnosis of bronchiolitis.
2. Clinicians should not administer epinephrine to infants and children with a diagnosis of bronchiolitis.
3. Nebulized hypertonic saline should not be administered to infants with a diagnosis of bronchiolitis in the emergency department.
4. Clinicians may administer nebulized hypertonic saline to infants and children hospitalized for bronchiolitis.
5. Clinicians should not administer systemic corticosteroids to infants with a diagnosis of bronchiolitis in any setting.
6. Clinicians may choose not to administer supplemental oxygen if the oxyhemoglobin saturation exceeds 90% in infants and children with a diagnosis of bronchiolitis.
7. Clinicians may choose not to use continuous pulse oximetry for infants and children with a diagnosis of bronchiolitis.
8. Clinicians should not use chest physiotherapy for infants and children with a diagnosis of bronchiolitis.
9. Clinicians should not administer antibacterial medications to infants and children with a diagnosis of bronchiolitis unless there is a concomitant bacterial infection, or a strong suspicion of one.
10. Clinicians should administer nasogastric or intravenous fluids for infants with a diagnosis of bronchiolitis who cannot maintain hydration orally.

Prevention

1. Clinicians should not administer palivizumab to otherwise healthy infants with a gestational age of 29 weeks, 0 days or greater.
2. Clinicians should administer palivizumab during the first year of life to infants with hemodynamically significant heart disease or chronic lung disease of prematurity defined as preterm infants <32 weeks 0 days' gestation who require >21% oxygen for at least the first 28 days of life.
3. Clinicians should administer a maximum 5 monthly doses (15 mg/kg/dose) of palivizumab during the respiratory syncytial virus season to infants who qualify for palivizumab in the first year of life.
4. All people should disinfect hands before and after direct contact with patients, after contact with inanimate objects in the direct vicinity of the patient, and after removing gloves.
5. All people should use alcohol-based rubs for hand decontamination when caring for children with bronchiolitis. When alcohol-based rubs are not available, individuals should wash their hands with soap and water.
6. Clinicians should inquire about the exposure of the infant or child to tobacco smoke when assessing infants and children for bronchiolitis.
7. Clinicians should counsel caregivers about exposing the infant or child to environmental tobacco smoke and smoking cessation when assessing a child for bronchiolitis.
8. Clinicians should encourage exclusive breastfeeding for at least 6 months to decrease the morbidity of respiratory infections.
9. Clinicians and nurses should educate personnel and family members on evidence-based diagnosis, treatment, and prevention in bronchiolitis.