Clinical diagnosis of Viral Bronchiolitis

A. Checking PCR, CXR or Labs are NOT indicated

- Judicious Suctioning
  - Evaluate need prior to feeds
  - Consider nasopharyngeal suction if nasal suction is inadequate
- Oxygen therapy for Sats ≤ 90%. Continuous pulse ox monitoring while on oxygen therapy.
- Check Sats every 4 hours with vitals. No continuous monitoring
  - Keep Sats between 90-94%
- Maintain adequate hydration
  - Consider NG tube for hydration and nutrition

- May consider 3% saline via neb every 4 hours for 24 hours and reassess
- No benefit of 3% saline use in ED to reduce admission
- There is NO benefit of Albuterol, Atrovent, Pulmicort, antibiotics, and chest PT

If patient with Asthma please refer to inpatient Asthma pathway

A. Clinical symptoms include, tachypnea, accessory muscle use, retractions, wheezing, decreased air movement
B. Clinicians may consider nebulized 3% hypertonic saline to hospitalized patients based on weak evidence, however use of 3% nebulized hypertonic saline does not reduce length of stay in a recent multi-center study
C. Chest PT does not improve the severity, respiratory parameters, or reduce length of hospital stay or oxygen requirements in hospitalized infants with acute bronchiolitis not on mechanical ventilation
D. Ipatropium Bromide (Atrovent) has not been shown to Improve the course of bronchiolitis
E. Pulmicort has not been shown to improve either short term or long term outcomes
F. Rescue bronchodilators or oral steroids have not been shown to improve outcome in bronchiolitis

Transfer to Higher Level of Care

- Persistent Hypoxemia
- Severe respiratory distress
- Respiratory failure requiring mechanical ventilation

Discharge criteria

- Clearing secretions by bulb suction (send home with home nasal suction)
- Able to take PO without hospital grade suction at least once
- Oxygen saturation on room air >90% for 6 hours
- No evidence of respiratory distress

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Owners: T.He, T.Wolfe
### Bronchiolitis Scoring System

<table>
<thead>
<tr>
<th>Clinical Variable</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Rate (&lt;2 years)</td>
<td>Less than 49</td>
<td>Greater or equal to 50</td>
<td></td>
</tr>
<tr>
<td>Accessory Muscle Use</td>
<td>None</td>
<td>Retractions (intercostal, substernal, subcostal)</td>
<td>Neck or abdominal muscles</td>
</tr>
<tr>
<td>Wheezes</td>
<td>Normal breath sounds or end expiratory</td>
<td>Entire expiratory</td>
<td>Entire expiration and inspiration</td>
</tr>
<tr>
<td>Air Exchange</td>
<td>normal</td>
<td>Localized decreased</td>
<td>Diffuse decreased</td>
</tr>
</tbody>
</table>

### Summary of Bronchiolitis Scoring System

1. Scoring should be assessed by respiratory therapist post-suction
2. Consider nebs if score is equal or greater than 3. – SABA nebs Q3hrs for up to 3 treatments – discontinue SABA if no improvement in the score
3. A decrease in score of greater or equal to 2 is considered significant improvement, suggestive of continued inhaled treatments.
4. If pre-treatment score is less than 3, nebs are not indicated.

### References


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