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As you are all likely aware, bronchiolitis season is underway and our wards are now regularly stocked with infants with lower respiratory tract disease. A welcome addition to our therapeutic armamentarium has been the publication of the recent AAP guideline, available via the AAP website <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;118/4/1774.pdf>.

We endorse the concepts in this guideline and are working to incorporate them into our inpatient care system. As a whole, they reaffirm the lack of proven therapies for bronchiolitis, outside of supportive rehydration and oxygenation. Two issues not completely addressed in this work are apnea and the search for serious bacterial infections in this population, with most studies focusing on RSV. There are reliable data in young infants with RSV bronchiolitis and fever that demonstrate a lower risk of serious bacterial infection than in previous studies of fever without source. It is difficult to make universal recommendations, but the work-up for fever in this population should probably be individualized with urinary tract infections remaining the most commonly found serious bacterial infection.

The data on the risk for apnea are far from definitive, with studies focusing only on hospitalized infants with lower respiratory tract disease caused by RSV. Hospitalized infants with a history of prematurity and those that are less than 1 month of age appear to be at higher risk for apnea. But there is no information on RSV-positive outpatients with minimal or no lower tract disease who clinically do not require hospitalization. In the absence of such data, it is likely prudent to base our admission decisions on the clinical appearance and course of each individual infant.

On a final note, it has been interesting that the evolution of the AAP guideline for bronchiolitis has been built on years of research, much of it done in Cincinnati. They have had a very similar guideline in place for over a decade and have achieved safe and effective decreases in resource utilization by partnering with local emergency room and community physicians. This town and gown mentality is a collaborative model which reaffirms our ability to make substantive changes to our health care system as a whole. We hope to partner with all care providers in the community to make similar improvements in the care of our children.