CLINICAL PRACTICE GUIDELINE
NEWBORN EMERGENCY TRANSPORT SERVICE (NETS WA)

Bronchiolitis

This document should be read in conjunction with the Disclaimer

Definition: viral infection of the lower respiratory tract manifesting as respiratory distress (and apnoea, especially in the young infant).

Management

- Provide oxygen as needed (Cot O_2 preferred to nasal prongs).
- CPAP if required. May be helpful in managing apnoea.
- Loading dose of IV Caffeine (20 mg/kg) if required.
- **Hypertonic Saline** (3%) has been shown to reduce airway oedema / increase mucous clearance and decrease secretion viscosity. Consider administering 2mLs 3% NaCl via nebuliser at referring hospital. Repeat as required.
- **Nebulised Adrenaline** has shown positive effects on short term measures including improved clinical score and reducing admission rates in the first 24 hours of care. Dose:
    - Using 1:1000 ampoule: 0.5 mL/kg/dose. Dilute to 2-4 mL with saline.
    - Using Respirator Solution: 0.05 mL/kg/dose.

Both Hypertonic Saline and Nebulised Adrenaline can only be administered at point of referral.

- Intubation and ventilation **after discussion with the on-call consultant**. Babies often deteriorate after intubation, and copious secretions may make ventilation difficult.
    - Sedation will be required.
    - Babies are prone to gas trapping.
    - Aim for lower rate, longer Ti (0.5-1.0) and Te, to allow better oxygenation and CO_2 removal but keep Ti < Te.
    - PEEP should generally be lower to avoid gas trapping, but higher PEEP may be needed in cases of atelectasis.
    - Regular ETT suction to prevent ETT occlusion.
- Nil by mouth, IV fluids at 2/3 maintenance.
- Start on antibiotics (Amoxicillin / Gentamicin).
- CXR (if available).

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