APPENDIX B

THE FOLLOWING INVESTIGATIONS HAVE NO EVIDENCE:

- Chest X-ray for diagnosis
- Venous blood gas measurement
- Blood tests
- Nasopharyngeal aspirate for RSV testing should only be considered if patient is admitted to a ward for infection control
  - It is not to be done routinely
  - It should not delay the disposition plan
  - It does not assist with diagnosis or treatment of bronchiolitis

THE FOLLOWING TREATMENT INTERVENTIONS HAVE NO EVIDENCE:

- Salbutamol nebulizer
- Epratropium Bromide nebulizer
- Adrenaline nebulizer
- Corticosteroids in any form
- Antibiotics
- Routine deep nasal suctioning
- Saline nebulisation

THE FEEDING CONUNDRUM:

- Determine whether the patient is feeding adequately:
  - In breastfed infants, ask mom whether the child is feeding for a shorter time than usual, or refuses to feed. Asking whether her breasts still "feel full" after a feed, how wet the nappies are and a clinical assessment of hydration status can help in assessing how well the baby is feeding.
  - In bottle fed infants, calculate the child’s maintenance volume of feeds\(^\text{5}\):
    - A baby normally drinks >120-150ml/kg of milk per day. Therefore, consider any amount > 60ml/kg/day as >50% of daily requirements. Chart 60-80ml/kg/day divided into 2 - 3 hourly doses for the first 24 hours until the child has been assessed as the stable. This will usually occur on the inpatient ward the morning following the admission.
    - In mild disease patient can usually still feed > 50% daily feeds by feeding smaller, more frequent feeds.
  - If feeding < 50% of usual time/ required volume despite above:
    - NG tube will be the next line of supportive treatment. In severe disease IV fluids may be appropriate first line hydration support. Seek senior advice.
    - Now, administer 2/3 of the maintenance volume calculated above. Babies with respiratory illness are prone to fluid retention secondary to SIADH\(^\text{5}\) therefore a reduced volume, i.e. 2/3 is indicated
      - Use formula or expressed breast milk
      - Continuous feeds for infants with severe distress – i.e. 2/3 the daily calculated maintenance volume over an hourly rate
      - 2 hourly bolus feeds for moderate cases: 2/3 daily maintenance divided by 12 (for 2 hourly feeds) = volume of each bolus every 2 hours – switch to continuous if child does not tolerate bolus feeds (vomiting: worsening distress).
      - Should the child vomit 2 or more times or develop worsening distress, IV fluid therapy is appropriate: administer 5% dextrose and 0.9% Normal saline at 2/3 hourly rate.
      - If the child tolerates the bolus well and appears to still be hungry, the bolus volume can be increased

\(^5\)SIADH: Syndrome of inappropriate ADH secretion