

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
- Ipratropium 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:⁶
 - 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[§] 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

[§]SIADH: Syndrome of inappropriate ADH secretion