key points

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Bronchiolitis shows a seasonal pattern with peak incidence occurring in the winter. Around 2-3% of children require admission to hospital. Admission rates are highest in infants less than three months old and those with underlying comorbidities. It typically affects children in the first year of life peaking between three and six months of age.

Infants will have a coryzal prodrome lasting one to three days before developing a persistent cough. Fever and reduced feeding are common and very young infants may present with apnoeic episodes. Symptoms normally peak between days three to five of the illness.

There will be evidence of increased work of breathing such as tachypnoea, indrawing/recession, head bobbing, grunting, nasal flaring or tracheal tug. Auscultation typically reveals wheeze and/or crepitations throughout both lung fields. Pneumonia should be considered if the fever is greater than 39° C or the chest signs are persistently focal.

Most children with bronchiolitis do not need to be referred to secondary care and can be managed safely at home. Immediate referral to hospital should be arranged if there is: apnoea (observed or reported), the child looks seriously unwell, severe respiratory distress, marked chest recession or a respiratory rate >70 breaths/minute, central cyanosis or persistent oxygen saturation < 92% when breathing room air.

When sending a child home key safety information should be given to parents. This includes: how to recognise developing red flag symptoms such as worsening increased work of breathing, fluid intake 50-75% of normal or no wet nappy for 12 hours, apnoea and cyanosis, exhaustion; how to get help if red flag symptoms develop; and arrangements for follow-up, if necessary.

Treatment of bronchiolitis consists largely of supportive management. The respiratory distress in bronchiolitis is caused by mucosal oedema and secretions rather than bronchoconstriction. Salbutamol and ipratropium have never been shown to produce any sustainable or clinically important benefits. Nor is there evidence to support antibiotics, montelukast, inhaled or systemic corticosteroids. Most clinicians recommend small amounts of fluid frequently.