Bronchiolitis stakeholder workshop 09-01-2013 Notes

Presentations

The group were welcomed to the meeting and informed about the purpose of the day. The workshop is an opportunity for stakeholders to review the draft scope and give their input on whether it is clinically relevant or appropriate.

The group received presentations about the work of NICE, the National Collaborating Centre for Women's and Children's Health (NCC-WCH) and the public involvement programme. The Chair of the guideline development group then presented the key elements of the draft scope.

Following questions, the stakeholder representatives were then divided into three groups. Led by a facilitator and a scribe, each group was asked to discuss the topics that had been proposed for inclusion and exclusion in the draft scope.

A summary of points discussed by the group is below

Please note that these points summarise comments made by a number of stakeholders and do not necessarily represent the views of all stakeholder.

1 Title

- One group suggested an alternative title for the guideline: "wheezy children younger than 2 years''

General comments

- All groups agreed that a clear definition of bronchiolitis should be made available to healthcare professionals
- Concise information about the condition, investigations and treatment should be given to parents and carers of children with suspected or confirmed bronchiolitis.

4.1 Population

- A group believed that it would be preferable to not define the population in terms of age. If the guideline is restricted to infants less than 1 year of age, a lot of evidence from North American studies might be excluded because they have a broader definition and those studies often include older children.
- A group suggested using several age cut-offs: less than 1 year (infants), less than 2 years, and less than 4 years in accordance with the American definition of bronchiolitis.
- Two groups agreed that only children less than 2 years should be included in this guideline because this would include most of the information relevant to the UK situation.

(Note that the age definitions used in other NICE guidelines is the following: neonates (0-4 weeks); infants (4-52 weeks); pre-school children (1-5 years)).

- Some comorbidities/high risk subgroups were identified and it was suggested that perhaps should be included in the scope:
    - Prematurity
    - Heart disease
    - Immunodeficiency
    - Genetic syndromes

    - Neuromuscular diseases
    - Lung disease
    - Cystic fibrosis

- All groups agreed that children with asthma should remain excluded from the guideline population. A group also suggested removing the word “recurrent” out of ‘children with other respiratory conditions, such as asthma or recurrent viral induced wheeze’.
- A group suggested excluding from the guideline children invasively ventilated and immuno-compromised.
- Some groups suggested that neonates already receiving care in neonatal units should be excluded because the infection is very rare in this population and these neonates are already receiving highly specialised clinical care.

4.2 Healthcare setting

- A group suggested that healthcare setting should explicitly include home management.
- A group suggested that neonatal units and intensive care units should be excluded

4.3 Clinical management

4.3.1 Key clinical issue that will be covered

Diagnosis and monitoring

- The equipment needed will vary depending on the age of the child.
- A group believed that SpO2 monitoring should be moved under Diagnosis and monitoring.
- It was agreed that SpO2 monitoring is an important topic. The guideline should also consider the use of SpO2 monitoring in primary care – links to criteria for referral to secondary care. There are health economic (HE) implications for this review.
- A group believed that the topic should be extended to include work of breathing/respiratory distress assessments. The specific frequencies of monitoring should not be included as this will be down to individual care plans. Reviews and recommendations on work of breathing assessments should be linked/cross-referred to those on the criteria for referral.
- A group noted that basic equipment is required for diagnosis of bronchiolitis and this should be accessible across primary care centres.

Investigations

- All groups suggested the inclusion of viral testing, in particular to aid cohorting of patients to reduce viral transmission within hospitals. A group suggested the importance of point of care (PoC) versus lab testing, as it gave an immediate result that allowed appropriate cohorting.
- A group stressed the importance of having clear guidance on to whom and when to perform investigations. In particular, in relation to viral testing.
- There was a general agreement that chest radiograph (CXR) needed to be in the scope.
- A group has suggested including full blood count, CRP and lumbar puncture to the list of investigations for serious bacterial illness.

Treatments

- There was general agreement that chest physiotherapy should be in the scope – some believed that it is important to consider specific high-risk subgroups as there may be evidence of effectiveness in these.
- Antibiotics - there was general agreement that there is a need for recommendations on the appropriate use of antibiotics treatment. A group suggested that there may be the need to differentiate between the use in neonatal intensive care unit (NICU)/pediatric intensive care unit (PICU) and non-intensive care unit.

- Combined therapy - A group believed that currently there are in use in the NHS more relevant combination therapies than the one suggested in the scope, these should be included, e.g. hypertonic saline plus adrenaline
- A group has suggested that bronchodilators may not be effective in premature babies and high-risk subgroups should be considered separately.
- Heliox – new trial due to be published in Pediatrics (within 6 months). 300 participants, based in UK/Austrialia. There are HE implications for this intervention so it should be prioritised for HE analysis. However, one group believed that heliox is currently rarely used in the NHS and could be removed from the scope.
- There was a general agreement that Montelukast is rarely used and could be removed from the scope
- Ribavirin is rarely used in the NHS and might be removed from the scope. However, a group has suggested that it is useful in certain high-risk subgroups, if retained in the scope this could be another HE priority
- A group suggested adding surfactants to the scope. For inhaled therapies, include both nebulisers and spacer devices need to be included.

Supportive measures

- A group felt that nutrition and hydration are very important topic areas. The criteria for starting supportive hydration should be included
- There was general agreement that high-flow ventilation should be included – note this is already specified in the clinical question but could be clarified in section 4.3.1. Brand names for this technology include Optiflow and Vapotherm [include in protocols]
- There was general agreement in removing post bronchiolitis antibiotics from scope. However, there may be a link to respiratory syncytial virus (RSV)/viral testing. Therefore, if RSV/viral testing is included in the scope this might need to be considered.
- A group has suggested adding positioning as another supportive measure.

Discharge criteria

- There was a general agreement that this section needed to be expanded. Criteria may include points such as feeding well, not requiring oxygen for a specified number of hours, safe levels of oxygen saturation etc.

4.3.2 Clinical issue that will not be covered

- There was general agreement on the areas that would not be covered by the guideline.
- A group believed that immunoprophylaxis could be included as there is conflicting advice and a lack of implementation of the existing Joint Committee on Vaccination and Immunisation (JCVI) guidance.

4.4 Main outcomes

In addition to the outcomes included in the scope, the following were suggested:

- invasive ventilation
- readmission rate within 7 days
- hospital acquired RSV

GDG composition

- There was general agreement with the suggested GDG composition.
- In addition, a number of other healthcare professionals were suggested, either as full GDG members, co-opted or as expert advisor:
    - A physiotherapist would be useful for the physiotherapy review – this could be an expert advisor or co-opted.
    - Possibly to have an infection control practitioner and health visitor as external advisors or co-opted.

- A microbiologist as group member or co-opted.
- Neonatologist (if neonate are covered) as expert advisor
- Paediatrician with special interest in cardiology group member or co-opted

Following the group work, all of the attendees were thanked for their work and the meeting was closed.