National Institute for Health and Care Excellence

Bronchiolitis
Guideline Consultation Table
17 November 2014 - 5 January 2015

ID	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
84	SH	AbbVie Ltd	1	Full	General	General	AbbVie are delighted that the guidelines have been updated and feel this is an important development given that the guidelines note that the number of admissions to hospital with bronchiolitis has been increasing over the last 20 years. AbbVie generally welcomes the revisions made to the guidelines but would note the lack of data used when developing parts of the guidelines. For example there has been little consideration of the financial burden of bronchiolitis. We know that hospital admissions due to acute bronchiolitis place a growing burden on NHS resources and finances. In the UK, hospital admissions of infants with bronchiolitis have increased by 50% in the period from 2004 to 2011[1] but there has been little work to consider the impact this has had. When developing these guidelines it would have been useful to have identified the causes of variation in the rate of emergency admissions and also explored evidence around reducing emergency admissions for children with acute bronchiolitis. The data currently collected on bronchiolitis by the NHS are not sufficiently detailed to allow	Thank you for your comment. The epidemiology of bronchiolitis and current practice is covered in the introduction of the full guideline and in the scope of the guideline. This guideline aims to help health care professionals in identifying and managing bronchiolitis based on the best available clinical and cost effective evidence. Increasing the identification (and hence accurate coding) of bronchiolitis will help better delineate the burden of bronchiolitis and the health and economic consequences to the NHS. Implementation tools will be made available with the publication of this guideline which will help commissioners and local providers in implementing the recommendations from this guideline. We have passed your comments on data systems to the NICE

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							commissioners and service providers to monitor the outcomes of the prevention and management interventions they make available. For example, the data currently collected by the NHS do not capture the number of admissions for children at highest risk of bronchiolitis, such as premature babies, and cannot be interrogated to identify the cause of the admission, whether the patient has been admitted previously, what previous interventions have been provided, or what their outcomes were. As a result, good practice guidance based on NHS data has not been developed, and it is challenging for commissioners and service providers to assess the value of their interventions. [1] PICANet, *2013 annual report: Summary report*, 2013. Available from http://www.picanet.org.uk/Audit/Annual-Reporting/PICANet_Annual_Report_2013_Summary.pdf. Accessed: 22 September 2014	implementation support team to inform their support activities for this guideline.
85	SH	AbbVie Ltd	2	Full	General	General	AbbVie feel the guideline could be further strengthened through specific reference to reducing the seasonal impact of lower respiratory tract infections (LRTIs) in infants and children.	Thank you for your comment. We consider that this is covered in the epidemiology section of the introduction to the full guideline.
86	SH	AbbVie Ltd	3	Full	General	General	AbbVie welcome much of the detail included in the guidelines but would like to see the guidelines include more specific information on the infants and children and groups that are more likely to be at risk of bronchiolitis. For example, in high risk populations such as infants with CHD, or those born prematurely with	Thank you for your comment. We acknowledge the importance of tobacco smoke exposure and have made reference to this in recommendation 14. Regarding the other risk factors you refer to, please see recommendations 10 and 16 on the risk factors to be considered when deciding whether to refer and

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							low birth weight and/or with BPD/CLD, bronchiolitis may result in a prolonged stay in hospital and supportive care on paediatric intensive care units, including ventilation[1]. Tobacco smoke exposure and overcrowding of family homes have been shown to be socio-economic prognostic factors for increased risk of severe RSV infection requiring hospitalisation. These risk factors are indicators of social deprivation and more likely to be experienced by families on lower incomes, often living in poor housing conditions. Infants born into such families are thus more vulnerable to RSV infection. There are several documented risk factors for severe RSV infection requiring hospitalisation, including pollution/exposure to passive smoking, day care attendance, school age siblings, overcrowding in the family home, lack of breastfeeding and age at the start of the RSV season[2,3,4]. [1] Simoes EAF**. Respiratory syncytial virus infection**. *Lancet* 1999; 354: 847–52 [2] Figueras-Aloy J, Carbonell-Estrany X & Quero J. **Case-Control Study of the Risk Factors Linked to Respiratory Syncytial Virus Infection Requiring Hospitalization in Premature Infants Born at a Gestational Age of 33–35 Weeks in Spain**. *Pediatric Infect Dis J* 2004; **23**: 815–820 [3] Figueras-Aloy J, Carbonell-Estrany X, Quero-Jimenez J et al. **Risk Factors Linked to Respiratory Syncytial Virus Infection Requiring**	admit a child with bronchiolitis; and chapter 3.2 of the full guideline. We have also acknowledged the importance of the family and carers social circumstances when considering whether to refer, admit or discharge in recommendations 11, 16 and 19. Regarding the papers that you identified: 1: Simoes (1999) was not identified in our literature search as it was outside of the review protocol. 2: Figueras-Aloy et al. (2004) was included in the review. 3: Figueras-Aloy et al. (2008) was included in the review. 4: Holburg et al. (1991) was identified but then excluded from the review. For further details on excluded studies and reasons for exclusions, please see appendix H.

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							Hospitalization in Premature Infants Born in Spain at a Gestational Age of 32 to 35 Weeks. *Pediatric Infect Dis J* 2008;**27**: 788–793 [4] Holberg C, Wright A, Martinez F et al. **Risk factors for respiratory syncytial virus-associated lower respiratory illnesses in the first year of life**. *American J Epidemiology* 1991, **133**; 1135-1151	
41	SH	Alder Hey Children's NHS Foundation Trust	1	Full	General	General	This guidance seems to be directed at the primary/secondary care interface. It would be helpful to also include guidance which might assist the management of patients being transferred to specialist paediatric units for intensive care management (ie secondary to tertiary care). In this situation many of the products which are not endorsed for use in bronchiolitis are used to support patients awaiting transfer e.g. adrenaline,ipratropium etc.	Thank you for your comment. No evidence was identified to support the use of agents such as adrenaline and ipratropium in any setting. No recommendation could therefore be made on their use in the setting suggested.
42	SH	Alder Hey Children's NHS Foundation Trust	2	Full	General	General	NICE guidance on palivizumab is desperately required and yet is seems to have been dismissed in a single sentence in this guideline. Can more information be included on palivizumab-particularly in babies with congenital cardiac disease – or can this be highlighted as a topic for joint guidance from NICE & JCVI to address	Thank you for your comment. Palivizumab is outside the scope of this guideline. We have passed your comment to the NICE technical appraisals team to inform their support activities for this guideline.
43	SH	Alder Hey Children's NHS Foundation Trust	3	Full	General	General	The use of blood gas analysis (some consultants felt that it might be better to have a lower threshold for taking a blood gas than is suggested in the guideline or including work of breathing in the guidance rather than just oxygen requirement).	Thank you for your comment. The committee considered this matter carefully and thought that the current recommendation for children with severe worsening respiratory distress (when supplemental oxygen concentration is greater than 50%) or suspected impending respiratory failure was appropriate and would limit unnecessary

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								investigation, The committee reached a consensus that children with an oxygen requirement over 50% FiO2 could be considered to be in severe worsening respiratory distress and therefore capillary blood gas testing may help guide further management
44	SH	Alder Hey Children's NHS Foundation Trust	4	Full	General	General	The guidance states that a patient should be admitted and not discharged if they are taking less than 75% of their feed requirement. I think we all discharge patients who are taking less than this and also we don't always admit these patients. Maybe the recommendation could look to lower this volume or state consider admission if taking less than 75% feed requirement.	Thank for your comment. The recommendations concerning feed volume have been updated following stakeholder consultation to include a range of 50% - 75% as a threshold. Please see section 3.4.7 of the full guideline for further information on the committee's deliberations.
6	SH	Associate of Paediatric Emergency Medicine	4	Full	2.1	17	Include some description of a tiring or exhausted child	Thank you for your comment. The recommendation contains a description of an exhausted child "for example, not responding normally to social cues, wakes only with prolonged stimulation".
7	SH	Associate of Paediatric Emergency Medicine	5	Full	2.1	17	Feeds of < 75% - we suspect this will draw the most comments as virtually all children with bronchiolitis will have a modest reduction in feed volume. Concern that using 75% rather than may lead to an increased number of unnecessary referrals. Practically, gauging a reduction in feeds to less than half normal seems to be easier to do, especially for those babies being breast fed.	Thank for your comment. The recommendations concerning feed volume have been updated following stakeholder consultation to include a range of 50% - 75% as a threshold. Please see section 3.4.7 of the full guideline for further information on the committee's deliberations.
8	SH	Associate of Paediatric Emergency Medicine	6	Full	2.1	17	See above re volume of feeds for admission criteria	Thank for your comment. The recommendations concerning feed volume have been updated following stakeholder consultation to include a range of 50% - 75% as a threshold. Please see section 3.4.7 of the full

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								guideline for further information on the committee's deliberations.
9	SH	Associate of Paediatric Emergency Medicine	7	Full	2.1	17	Define saturations of less than or equal to 92% , or less than 92% as discussions in the full guideline comments on O2 sats of 90% being acceptable. Define "persistent"saturations	Thank you for your comment. Single measurement requires repeating and clinical judgement would be used in determining the duration of monitoring, for example a vigorous older infant might be monitored for a shorter period than a young potentially vulnerable infant. There is no evidence to define 'persistent' - it is recognised that short self-resolving fluctuations in SpO2 appear to have no repercussions and are not therefore considered to require intervention in bronchiolitis We have not therefore stipulated the duration of monitoring that would constitute an adequate duration for 'persistent'.
5	SH	Associate of Paediatric Emergency Medicine	3	Full	2.2	17	See above re comments of O2 saturations below 92% for referral to secondary care. What is the definition of "persistent" in this context	Thank you for your comment. Single measurement requires repeating and clinical judgement would be used in determining the duration of monitoring, for example a vigorous older infant might be monitored for a shorter period than a young potentially vulnerable infant. We have not therefore stipulated the duration of monitoring that would constitute an adequate duration for 'persistent'.
4	SH	Associate of Paediatric Emergency Medicine	2	Full	2.2.20	21	Oxygen saturations are hardly ever done in primary care because they do not have the appropriate age related equipment. When they are done, spurious results are obtained and the infant is referred into secondary care. If they are to be done, then appropriate equipment and training on	Thank you for your comment. We agree and given that there are no studies to inform the use of SpO2 measurement in primary care we have included a research recommendation on the clinical and cost effectiveness of SpO2

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							this equipment must be emphasised. It be argued that O2 saturations are part of the clinical assessment in primary care, but is there any evidence to support that not having this information is detrimental to the patient, or alters the referral process?	measurement in primary care.
12	SH	Associate of Paediatric Emergency Medicine	10	Full	2.2.20	21	Discharge advice on feeding – is this based on the > 75% volume as per the referral/admit cut off? If so, what is, and how strong is, the evidence?	Thank you for your comment. The recommendation on providing parents or carers with key safety information (which is related to recommendation 14) if the child is not admitted was based on the committee's consensus.
13	SH	Associate of Paediatric Emergency Medicine	11	Full	2.2.20	21	Oxygen saturations should be > 92% in air for 4 hours – is this period of time evidenced?	Thank you for your comment. This was based on committee consensus. For full details on their deliberations please see sections 3.3.7 and 3.4.7 of the full guideline.
11	SH	Associate of Paediatric Emergency Medicine	9	Full	2.2.39	22	"Perform upper airway suctioning in children with bronchiolitis presenting with apnoea **even if no obvious upper airway secretions**" – there is no discussion as to why this should be done	Thank you for your comment. Please see section 5.2.4 of the full guideline for further details on the committee's deliberations to justify this recommendation. The committee agreed that suctioning is not a treatment for bronchiolitis. Moreover, it can be distressing for the child, parents and carers. The committee was concerned that frequent suctioning, the use of excessively powerful suction pressures, or an incorrect or forceful technique could cause injury to the tissues of the nose or upper airway and therefore they agreed that suctioning should not be routinely performed in

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								children with bronchiolitis.
3	SH	Associate of Paediatric Emergency Medicine	1	Full	2.2.8	19	To include CLD, CHD, prematurity etc seems helpful. To include male sex, not breast fed or from a household of smokers does not. This is statistically interesting but in practise does not add to the clinical picture	Thank you for your comment. This recommendation has now been removed following stakeholder consultation.
10	SH	Associate of Paediatric Emergency Medicine	8	Full	4	171	There is no comment made or discussion of the use of NPA in the management of bronchiolitis. Should this be used in particular clinical situations such as 1) a high risk infant due to prematurity or co-morbidities 2) clinical deterioration 3) cohorting concerns	Thank you for your comment. Bronchiolitis is a clinical diagnosis and the severity of the condition is judged clinically too. Knowledge of an NPA result helps with hospital based cohorting, but the overall impact of knowledge of viral cause of bronchiolitis on management and outcome is very limited. For this reason the use of NPA was outside of this guideline scope. The cohorting concerns are outside of scope of this guideline as this is part of hospital infectious disease control policy.
40	SH	Association of Anaesthetists of Great Britain and Ireland (AAGBI)	1	Full	3.59	153	No recommendation is made on the volume of maintenance fluid to be given to children with bronchiolitis. Many children with severe bronchiolitis have hyponatraemia (see references) and these children would benefit from fluid restriction. Moreover, a recent survey of infants referred to South Thames Retrieval Service (STRS) showed that 29% of patients received 100ml/kg/day or more of fluid and 22% were hyponatraemic (data available, to be published). Guidance should be given on fluid restriction in severe bronchiolitis. Hanna S, Tibby SM, Durward A, Murdoch IA:	Thank you for your comment. We have issued a recommendation in terms of composition of fluid to be given in line with NPSA guidance. Specific guidance on volumes of maintenance fluids has not reviewed as part of this guideline, however, this is within the scope of another guideline currently under development (IV fluids in children (publication expected 28 October 2015)).

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							Incidence of hyponatraemia and hyponatraemic seizures in severe respiratory syncytial virus bronchiolitis. Acta Paediatr 2003, 92(4):430-434. Eisenhut M: Acute bronchiolitis: Risk of hyponatraemia.[comment].BMJ 2007, 335(7630):1109 Lillie J, Tibby S, Riphagen S: Management of bronchiolitis prior to PICU. STRS survey unpublished.	
80	SH	British Infection Association	1	NICE	General	General	We are surprised that there is no mention of the value or otherwise of making a diagnosis of a virus infection in patients with bronchiolitis. Does the absence of a recommendation to send a nasopharyngeal aspirate for virological diagnosis mean that the panel believe that this is an ineffective investigation?	Thank you for your comment. The diagnosis of viral infections is outside the scope of this guideline.
63	SH	British Paediatric Respiratory Society	19	Full	1.6.2	11	Last sentence states that process of reviewing published evidence was complete by Aug 2014. Hence this methodology would exclude SABRE trial	Thank you for your comment. The SABRE trial has not been excluded and this section has been revised to clarify the searching cut-offs used in the development of this guideline.
67	SH	British Paediatric Respiratory Society	23	Full	2.2	19	Under recommendation 10 it says that if a child is clinically dehydrated in primary care consider referral to secondary care. This differs from page 140 which states that any child who is clinically dehydrated should be referred for secondary care – which is the guideline going to recommend. My feeling is that any child who is clinically dehydrated should be referred to secondary care	Thank you for your comment. The committee consider that while in many cases an infant with clinical signs of dehydration would require referral to hospital, there were occasional circumstances where this was not immediately necessary.
65	SH	British Paediatric Respiratory Society	21	Full	3.2.5.2	117	Multiple births – I don't understand the sentence "multiple birth associated with reduced risk of hospitalisation and another that singleton birth increases risk of hospitalisation. Multiple birth is associated with reduced clinical threshold for	Thank you for your comment. The full guideline has been amended to state that singleton birth reduces the risk of hospitalisation.

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							admission". One of these statements is the wrong way round.	
66	SH	British Paediatric Respiratory Society	22	Full	3.4.7.2	140	I think that a RR 60-70 should have a stronger emphasis on low threshold for referral to secondary care (para 3)	Thank you for your comment. The committee considered that a respiratory rate could be taken in context of other clinical features, particularly in younger infants. There was consensus that a respiratory rate of 60 should prompt consideration of referral (and hence consideration of admission).
64	SH	British Paediatric Respiratory Society	20	Full	General	General	Down syndrome is spelt Down**s** syndrome throughout the document. There is no S in Down	Thank you for your comment. However, the committee believes that Down's Syndrome is the correct spelling.
54	SH	British Paediatric Respiratory Society	10	NICE	1.1.10	10	who is the point about ensuring HCPs are trained aimed at?	Thank you for your comment. The guidance is aimed at all healthcare professionals involved in the care of children with bronchiolitis.
51	SH	British Paediatric Respiratory Society	7	NICE	1.1.4	9	by referring to symptoms as "common" does this indicate they are common in bronchiolitis and therefore might indicate bronchiolitis, or common anyway and might not indicate bronchiolitis?	Thank you for your comment. The symptoms are common in bronchiolitis. We have updated recommendation to include "young infants with this disease" to clarify this.
53	SH	British Paediatric Respiratory Society	9	NICE	1.1.9	10	we thought that all GP surgeries and A&E departments should have pulse oximetry?	Thank you for your comment. Pulse oximetry is not always available in primary care and no evidence for its clinical and cost effectiveness in primary care was identified. The committee therefore developed a research recommendation on its effectiveness. Please see section 2 of the NICE guideline for further details.
55	SH	British Paediatric Respiratory Society	11	NICE	1.2	11	this is about emergency referral – should this be made more prominent, and perhaps moved to the beginning of the recommendations section? The same applies to 1.2.2	Thank you for your comment. The order that the recommendations are presented reflects the care pathway and this recommendation is at the beginning of

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								the section on referral.
56	SH	British Paediatric Respiratory Society	12	NICE	1.2	11	there are risks listed in 1.1.6 which are not included here. Could there be more clear guidance about when to refer and when to consider referring?	Thank you for your comment. The committee agree that it was confusing to have different sets of risk factors. Following stakeholder consultation, the recommendation you mention has been deleted.
57	SH	British Paediatric Respiratory Society	13	NICE	1.2.3	12	the same applies here – the various lists should match?	Thank you for your comment. The committee agree that it was confusing to have different sets of risk factors. Following stakeholder consultation, the recommendation you mention has been deleted.
45	SH	British Paediatric Respiratory Society	1	NICE	General	4	The last paragraph on this page refers to young people with bronchiolitis. However, elsewhere (pages 3, 9) there are references to bronchiolitis occurring in infancy. It would be helpful to clarify whether bronchiolitis is a disease that only affects infants. Is the transition paragraph about children who go on to develop other diseases as a result of bronchiolitis, or about older children affected by bronchiolitis? The SIGN guidelines (attached) offer some explanation about different age groups. Also on page 4 there is reference to the DH transition document. This is a lengthy guideline from 2006. A transition toolkit has been developed recently by Southampton called Ready Steady Go – it might be helpful to reference this or another more recent example also. http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx	Thank you for your comment. The introduction has been updated to read children with bronchiolitis. Please note that we do not normally refer to external documents in this way.
46	SH	British Paediatric	2	NICE	General	General	General points:	Thank you for your comments. The guideline applies broadly to healthcare

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		Respiratory Society				(7-21)	There is quite a bit of repetition and this section could be clearer. It would be very helpful to be clear which parts of the guidelines are aimed at which health care professionals, both in the 2 page summary on pages 7 and 8, and also in the detailed section from page 9 to 21. For example, there could be a section for GPs and then a section for secondary care, with also perhaps another section at area level e.g. re training mechanisms and organisational structure. It would be also helpful in this section to separate out or clearly distinguish between the 'musts' and 'must nots', and the 'shoulds' and 'should nots', as described on page 5; the phrase "take into account" is used, and the word "consider" is also used, and it is not always immediately clear what this means. The SIGN guidelines have a systematic way to present their recommendations; there are 4 grades of recommendation based on the evidence available, and good practice points are marked with a tick. They also use the words 'must', 'should' etc. in the body of the guidelines. Specific points: Is it worth defining coryzal prodrome? I understand that medical people will understand this but others may not (I didn't!). There are references on several pages to apnoea – I think it would be helpful to be more specific here – asleep or awake, for how long in duration and how often? My reasoning is to differentiate between apnoea associated with bronchiolitis and	professionals who work in the NHS. Please see 'strength of recommendations' section on page 5 of the NICE guideline for further details on the wording used to inform NICE guideline recommendations. Coryzal prodrome is now defined in section 3.1.7.2 of the full guideline. The recommendation has been updated with the words "with this condition"

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							that which is OSA. I don't think the SIGN guidelines explain this either unless I have missed that.	
47	SH	British Paediatric Respiratory Society	3	NICE	General	7	it says that when diagnosing bronchiolitis, take into account young infants may present with apnoea without other clinical signs – does this infer that they could nevertheless have bronchiolitis – this is not clear to me?	Thank you for your comment. The recommendation has been updated with the words "with this condition".
48	SH	British Paediatric Respiratory Society	4	NICE	General	8 (and others)	Montelukast should be a lower case "m"	Thank you for your comment. This has been amended throughout the guideline.
49	SH	British Paediatric Respiratory Society	5	NICE	General	8	red flag symptoms – it is great to see these but they look somewhat lost in the text – could they be written into a chart or made clearer in some other way?	Thank you for your comment. The red flag symptoms need to stay as a list within the recommendation rather than in a separate box as having them separately would cause issues for users working with the pathway in the NICE mobile app, and possibly on printouts that people make for themselves of the web viewer version.
50	SH	British Paediatric Respiratory Society	6	NICE	General	9	refers to bronchiolitis occurring in children under 2 – does this imply it ONLY occurs in children under 2? See above point re page 4. It would be very helpful if this could be made clear especially for GPs.	Thank you for your comment. The committee agreed by consensus that bronchiolitis occurs in infants and to a lesser degree, in children between age 1 and 2 years.
52	SH	British Paediatric Respiratory Society	8	NICE	General	10	confused about who the guidance was aimed at.	Thank you for your comment. The guidance is aimed at all healthcare professionals involved in the care of infants and children with bronchiolitis.
58	SH	British Paediatric Respiratory Society	14	NICE	General	17	was this statistically significant?	Thank you for your comment. Unfortunately we are unsure what you are referring to.
59	SH	British	15	NICE	General	17	we were not clear if the first sentence means	Thank you for your comment.

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		Paediatric Respiratory Society					hospitalised cases who are not maintaining their SpO2 – could this be clarified?	Unfortunately we are unsure what you are referring to.
60	SH	British Paediatric Respiratory Society	16	NICE	General	General Various locations	Clinical dehydration and/or reduced oral intake below 75% expected are both suggested as indications to consider secondary care referral. I would suggest that a clinically dehydrated infant with bronchiolitis should be in hospital, and that clinical dehydration should be moved to there absolute indications for referral to secondary care.	Thank you for your comment. The committee considered that while in many cases an infant with clinical signs of dehydration would require referral to hospital, there were occasional circumstances where this was not immediately necessary.
61	SH	British Paediatric Respiratory Society	17	NICE	General	General	It would be useful to have a consensus recommendation on the potential place for the use of vapotherm in the NICE therapeutic pathway would aid clarity even without definitive evidence of superiority over simple oxygen therapy.	Thank you for your comment. Experience with high flow humidified oxygen is limited. The committee were not able to provide consensus recommendations on its use.
62	SH	British Paediatric Respiratory Society	18	NICE	General	General	It would be useful to have a consensus statement on the potential use of antibiotics and possibly nebulised hypertonic or even 0.9% saline for patients requiring HDU management with lobar consolidation/ collapse	Thank you for your comment. The committee did not consider the medical management of lobar consolidation/collapse strategies in the HDU, as it was understood that evidence and experience would be too limited to provide satisfactory statements.
81	SH	Department of Health	1	NICE	General	General	Thank you for the opportunity to comment on the draft for the above clinical guideline. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment.
1	SH	HQT Diagnostics	1	Full	General	General	Suggest test for Fatty Acids and supplement with Omega-3 for 3 months alongside drug treatment Re-test after 3 months, with the objective of reducing amount of drugs. **Target:** Omega-3 Index >8%	Thank you for your comment. This is outside the scope of the guideline.

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							Omega-6/3 Ratio <3:1 For more information: www.expertomega3.com/omega-3-study.asp?id=21#4.7. www.hqt-diagnostics.com www.hindawi.com/journals/jir/2012/730568/	
2	SH	HQT Diagnostics	2	Full	General	General	Suggest test for Vitamin D 25(OH)D levels and supplement to 75-100 nmol/L for 3 months alongside drug treatment Re-test after 3 months, with the objective of reducing amount of drugs For more information: www.vitamindwiki.com/Breathing	Thank you for your comment. This is outside the scope of the guideline
39	SH	Neonatal and Paediatric Pharmacists Group	4	Full	2.3	23	We are pleased to see the research recommendation looking at the efficacy of montelukast in the treatment of acute bronchiolitis in infants and children.	Thank you for your comment.
38	SH	Neonatal and Paediatric Pharmacists Group	3	Full	4.2.13.6	274	We note the comments in paragraph 5 regarding methods of administering montelukast in children however we would like to point out that as well as the granules, a chewable tablet is available. This montelukast tablet can be dispersed in water for administration to younger children. (Ref: Smyth J, editor. The NEWT Guidelines [Internet]. Wrexham: Betsi Cadwaladr University Local Health Board (East); 2012. [cited 2014 Dec 24]. Available from: http://www.newtguidelines.com/)	Thank you for your comment. Method of administration was not pre-specified in the review protocol, however the two included studies for this review used montelukast in granules, therefore the paragraph in the Linking Evidence to Recommendations section in the full guideline refers to the reviewed evidence.
36	SH	Neonatal and Paediatric Pharmacists Group	1	NICE	1.4.3	13	We agree with the recommendation that these medicines should not be used to treat bronchiolitis in children	Thank you for your comment.

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37	SH	Neonatal and Paediatric Pharmacists Group	2	NICE	2.3	17	We agree with the research recommendation looking into the efficacy of combined bronchodilator and corticosteroid therapy. We are pleased to see that this has been prioritised.	Thank you for your comment.
79	SH	NHS Choices	1	NICE	General	General	The Digital Assessment Service welcome the guideline and have no comments as part of the consultation	Thank you for your comment.
89	SH	Primary Care Respiratory Society (UK)	3	Full	2.1	17	"*Immediately refer children with bronchiolitis for emergency hospital care (usually by 999 ambulance) if they have any of the following:….*" Delete the word "*usually*" for clarity. These children are at risk of respiratory arrest and should not be transported by parents in the back of their car. A clear recommendation for 999 ambulance transfer flags the severity of the condition and the urgency of transfer and the availability of oxygen.	Thank you for your comment. The committee included the word "usually" as in a minority of cases 999 ambulance is not the quickest way of getting to the hospital, e.g. transportation may be quicker via car than ambulance in rural areas.
90	SH	Primary Care Respiratory Society (UK)	4	Full	2.1	17	"*Provide key safety information for children who will be looked after at home. This should include information*:" Specify the provision of written information in the form of a pamphlet. Such pamphlets have been produced at a local level (example attached): written materials aid parental understanding . This local leaflet has a picture of a child who is rather old for the main group of affected children (and as you will see uses a 50% criterion for "reduced fluid intake of concern" – but the concept of such written materials is a good one and should be encouraged.	Thank you for your comment. The committee did not specify that the information had to be written as a variety of information methods may be appropriate to reach target audiences (e.g. if the parent/carer has learning or reading difficulties, or the availability of translated materials). The recommendation has been amended to read 'information to take away'.

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91	SH	Primary Care Respiratory Society (UK)	4a	Full	2.1	17	We wonder how the "*less than 75% of usual volume*" criterion has been chosen as the definition of reduced intake justifying hospital assessment and admission. This discussion comes in 3.4.7.2 p 140. (The quality of evidence is acknowledged to be low.) "*The GDG considered by consensus that an intake of 50-75% usual volumes should be considered as borderline intake. The lower limit of 50% may apply to an older infant with previous good health who is anticipated to improve over the subsequent 24 hours (i.e. illness day 3 or 4), with the upper limit of 75% applicable to a younger infant with possible risk factors (i.e. preterm) who may have poorer ability to tolerate a reduced calorie and fluid intake. The GDG considered by consensus that in primary care an assessment of oral intake between 50 and 75% of typical volume should take into account other clinical (i.e. work of breathing) and risk factors (i.e. age, chronic lung disease, Haemodynamically significant congenital heart disease etc) when deciding whether to refer to hospital.*" We therefore wonder whether the 50-75% range for "*reduced intake of clinical concern*" should be used when discussing this criterion. There is a risk (given that parents and professionals have trouble in quantifying this)	Thank for your comment. We agree and the recommendations concerning feed volume have been updated following stakeholder consultation to include a range of 50% - 75% as a threshold.

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							that using the 75% criterion may lead to a non-useful increase in referrals to hospital.	
92	SH	Primary Care Respiratory Society (UK)	5	Full	2.1	17	• inadequate oral fluid intake (less than 75% of usual volume) This is given as a criterion for "*considering*" hospital referral but then immediately afterwards given as a criterion for admission. Clarification needed.	Thank for your comment. The recommendations concerning feed volume have been updated following stakeholder consultation to include a range of 50% - 75% as a threshold. Please see section 3.4.7 of the full guideline for further information on the committee's deliberations.
93	SH	Primary Care Respiratory Society (UK)	6	Full	2.1	18	"*Do not perform a chest x-ray in children with bronchiolitis, because changes on x-ray may mimic pneumonia and should not be used to determine the need for antibiotics [Rec 28].*" Our commentator is sceptical of a blanket recommendation not to perform a chest X ray as it assumes complete reliability of clinical diagnosis. Possible alternative wording: "*Chest X ray is not normally needed in chldren with bronchiolitis because… > Chest X ray may be indicated if …*" then list the clinical or severity grounds that might warrant a chest X ray.	Thank you for your comment. We agree and have included a new recommendation on when to perform a chest x-ray following stakeholder consultation.
94	SH	Primary Care Respiratory Society (UK)	7	Full	2.1	18	"*Give oxygen supplementation to children with bronchiolitis if their oxygen saturation is persistently 92% or less [Rec 35].*" There should be clarity in the recommendation for the availability of pulse oximetry and oxygen in all urgent care and out–of-hours primary care providers (as a minimum) and preferably in all primary care premises. The	Thank you for your comment. Single measurement requires repeating and clinical judgement would be used in determining the duration of monitoring, for example a vigorous older infant might be monitored for a shorter period than a young potentially vulnerable infant. We have not therefore stipulated the duration of monitoring that would constitute an

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							availability of pulse oximetry in the ambulance/paramedic service as essential standard kit should be specifically mentioned here, since they are often the first port of call. We have an anecdotal example of a GP having to lend an ambulance his own pulse oximeter since it didn't have one when attending a respiratory emergency. We are aware that this recommendation for widespread availability of pulse oximetry for infants is potentially controversial but, given this is a key element of severity assessment and that oximeters and oxygen can be and are provided in many primary care facilities, and that oxygen is potentially lifesaving (and not just for bronchiolitis), we feel that a stronger statement should be made in the guideline. This recommendation is also made in the British Thoracic Society's 'Oxygen in children' guideline, so will be consistent.	adequate duration for 'persistent'. Specific reference to the use of pulse oximetry when measuring oxygen saturation is made in recommendation 24 of the full guideline. Pulse oximetry is not always available in primary care and no evidence for its clinical and cost effectiveness in primary care was identified. The committee has therefore developed a research recommendation. Please see section 2.3 of the full guideline for further details.
95	SH	Primary Care Respiratory Society (UK)	8	Full	2.2	18	*"4. When diagnosing bronchiolitis, take into account that young infants (in particular those under 6 weeks of age) may present with apnoea without other clinical signs.*" Should age under 6 weeks be added as a criterion for considering hospital assessment due to this apnoea risk?	Thank you for your comment. The committee has considered your point, but disagree that age under 6 weeks should be added as a criterion, instead considering that age under 3 months was more representative of those at highest risk.
96	SH	Primary Care Respiratory Society (UK)	9	Full	2.2	19	*"9. Immediately refer children with bronchiolitis for emergency hospital care* *(usually by 999 ambulance) if they have any of the following:"*	Thank you for your comment. The committee included the word "usually" as in a minority of cases 999 ambulance is not the quickest way of getting to the hospital, e.g. transportation may be

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							Delete "usually"	quicker via car than ambulance in rural areas.
97	SH	Primary Care Respiratory Society (UK)	10	Full	2.2	20	*"15. Provide key safety information for children who will be looked after at home. This should include information:"* Specify "written information"	Thank you for your comment. The committee did not specify that the information had to be written as a variety of information methods may be appropriate to reach target audiences (e.g. if the parent/carer has learning or reading difficulties, or the availability of translated materials). The recommendation has been amended to read 'information to take away
98	SH	Primary Care Respiratory Society (UK)	11	Full	2.2	21	"*19. Provide parents or carers with key safety information (see Recommendation 15) if the child is not admitted."* Specify "written information"	Thank you for your comment. The committee did not specify that the information had to be written as a variety of information methods may be appropriate to reach target audiences (e.g. if the parent/carer has learning or reading difficulties, or the availability of translated materials). The recommendation has been amended to read 'information to take away
99	SH	Primary Care Respiratory Society (UK)	12	Full	2.2	21	*"25. Measure oxygen saturation in every child presenting with suspected bronchiolitis, including those presenting to primary care if pulse oximetry is available.*" Delete "*if pulse oximetry is available*." The vast majority of assessment decisions on the need for hospital admission in children with bronchiolitis take place in primary care. We believe that primary care facilities should provide facilities for pulse oximetry and oxygen. A clear statement here would act as a driver for improved standards of assessment	Thank you for your comment. Pulse oximetry is not always available in primary care and no evidence for its clinical and cost effectiveness in primary care was identified. The committee has therefore developed a research recommendation. Please see section 2 of the NICE guideline for further details.

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							and management (and not just in children with bronchiolitis)	
100	SH	Primary Care Respiratory Society (UK)	13	Full	2.2	21	*"28. Do not perform a chest x-ray in children with bronchiolitis, because changes on x-ray may mimic pneumonia and should not be used to determine the need for antibiotics."* See note above	Thank you for your comment. We agree and have included a new recommendation on when to perform a chest x-ray following stakeholder consultation.
101	SH	Primary Care Respiratory Society (UK)	14	Full	2.2	22	*"34. Do not use any of the following to treat bronchiolitis in children:"* This clear and important statement might usefully be prefaced throughout by "There is no evidence for the effectiveness of any of the commonly used pharmacological treatments for bronchiolitis."	Thank you for your comment. Full details of the evidence that underpinned this recommendation can be found in the evidence to recommendations in sections 4.2.4.7, 4.2.10 and 4.2.14 of the full guideline.
102	SH	Primary Care Respiratory Society (UK)	15	Full	2.3	23	*"3. What is the clinical and cost effectiveness of SpO_2 measurement in a primary care setting in children with bronchiolitis?"* We agree that this is an important research question but that a strong recommendation on the availability of pulse oximetry in primary care remains justified prima facie.(see point 7 above) Is there evidence on the clinical and cost effectiveness of Sp02 measurement in hospital?	Thank you for your comment There is no evidence for the use of SpO2 in hospital practice, however pulse oxygen saturation monitors are ubiquitous in hospital care and an RCT of use would be ethically challenging. The use of SpO2 for infants in primary care is not widespread and the transition to more widespread use should be assessed for clinical and cost effectiveness.
103	SH	Primary Care Respiratory Society (UK)	16	Full	2.3	General	Given that the great majority of children with bronchiolitis are managed entirely in primary care there is a need for a general statement about the importance of conducting primary care based research into the assessment and	Thank you for your comment. We agree and have developed a research recommendation on the clinical and cost effectiveness of SpO2 measurement in a primary care setting in

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							management of this condition.	children with bronchiolitis
104	SH	Primary Care Respiratory Society (UK)	17	Full	2.3	24	*"9. What is the clinical and cost effectiveness of suction to remove secretions from the upper respiratory tract compared with minimal handling?"* For interest: In Zimbabwe in the 1980's, mothers used to suck (by mouth) to clear the nasal secretions of their babies if having trouble feeding for this reason. This did not seem to distress the babies or the mothers. We do not expect this recommendation would meet with great medical or parental enthusiasm in the UK, but thought it of interest in this context.	Thank you for your comment
105	SH	Primary Care Respiratory Society (UK)	18	Full	2.4	25	In the pathway : See above for observation on the ambiguity over whether "inadequate fluid intake" does or does not mandate hospital assessment – which it logically ought to if it is a criterion for admission.	Thank you for your comment. The care pathway has been updated following stakeholder consultation.
87	SH	Primary Care Respiratory Society (UK)	1	Full	General	General	PCRS (UK) welcomes the publication of this guideline on the management of a common and important respiratory problem in childhood. The overwhelming majority of cases are managed entirely within primary care, and primary care professionals play a vital role in identifying the minority of more severe episodes which require hospital treatment. This guideline will help improve primary care management of acute bronchiolitis.	Thank you for your comment.

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88	SH	Primary Care Respiratory Society (UK)	2	Full	General	General	Our comments will focus on the summary conclusions of the document (2.1-2.4). The searching and interpretation of the evidence base has been conducted with the customary thoroughness.	Thank you for your comment.
82	SH	Royal College of General Practitioners	1	Full	2.2	18 -22	Many thanks for this excellent summary. It would be a help to GPs to detail what we can advise the parents to do in looking after their infant or child with bronchiolitis if prescribing doesn't help. Should we advise not to take proprietary cough medicines and paracetamol? Steam? Albas oil? How to give fluids? What temperature room? What clothing? Not to share a bed? Importance of flu vaccine if not already had it? Continue breast-feeding? I know these are not evidence based. Red flags in a box or as a downloadable leaflet? (JA)	Thank you for your comment. The areas that you raise in your comment are outside of the scope of this guideline. The red flag symptoms need to stay as a list within the recommendation rather than in a separate box as having them separately would cause issues for users working with the pathway in the NICE mobile app, and possibly on printouts that people make for themselves of the web viewer version.
83	SH	Royal College of General Practitioners	2	Full	General	General	Thank you for the opportunity to review these guidelines. Nice to read some very clear and unambiguous guidance. (JH)	Thank you for your comment
17	SH	Royal College of Paediatrics and Child Health	4	Full	1	9	Says..."peaking in the winter months, most significantly over a 6-8 week period". We would add in brackets after that (usually in December/January in the UK).	Thank you for your comment. The committee do not consider that it is necessary to state specific months where this peaks.
18	SH	Royal College of Paediatrics and Child Health	5	Full	2.1	17	Says under primary care to consider referral to secondary care if infant is feeding <75% of usual volume (what if usual volume is way above maintenance requirements?) but in the secondary care section if feeding is <75% of usual volume this is a definite admission criteria- seems inconsistent. Also <75% seems quite high (if followed to the letter we have been advised that this would result in increased admissions i.e. an	Thank for your comment. The recommendations concerning feed volume have been updated following stakeholder consultation to include a range of 50% - 75% as a threshold. Please see section 3.4.7 of the full guideline for further information on the committee's deliberations.

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							otherwise well child- no acute resp issues- feeding only 2/3 [66%] of normal doesn't necessarily need admission especially if things are improving) (is <50% more realistic?)- Later in the document there is some discussion around using <50-75% with <75% to be used in infants with other risk factors but in the bullet point recommendations only <75% is mentioned. As this guideline is going to be used primarily by trainees (in a secondary care setting at least) we suspect many will use the 75% as an absolute cut off (although obviously it is meant to be used in the context of other risk factors/clinical parameters etc). Is the <75% feeding a severity marker of bronchiolitis or a complication of bronchiolitis?	
19	SH	Royal College of Paediatrics and Child Health	6	Full	2.1	18	Says do not use salbutamol, atrovent etc to treat bronchiolitis. In the small proportion with a significant wheeze component without crackles, might one not consider a trial of bronchodilators? This is considered in section 4.2.10.1 but is not in the recommendations elsewhere. Alternatively if only wheeze and no creps then diagnosis in VIW not bronchiolitis.	Thank you for your comment. The small number of babies that would benefit from this do not have bronchiolitis and are therefore outside of the scope of the guideline.
20	SH	Royal College of Paediatrics and Child Health	7	Full	2.2	19	Point 8- says "risk factor is premature birth <32 weeks" (should include "of gestational age")	Thank you for your comment. The recommendation has been amended.
21	SH	Royal College of Paediatrics and Child Health	8	Full	2.2	19	Point 10- re: feeding <75% as per point 2 above	Thank for your comment. The recommendations concerning feed volume have been updated following stakeholder consultation to include a range of 50% - 75% as a threshold. Please see section 3.4.7 of the full

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								guideline for further information on the committee's deliberations.
22	SH	Royal College of Paediatrics and Child Health	9	Full	2.2	20	Admission to hospital if <75% feed- as my point 2 above. Also in the parent red flag section it mentions no wet nappy for 12 hours but this (or urine output generally) is not mentioned in the "doctor's sections" (either primary or secondary care). Would markedly reduced urine output (<2-3 wet nappies/day) not be a referral/admission criteria?	Thank for your comment. The recommendations concerning feed volume have been updated following stakeholder consultation to include a range of 50% - 75% as a threshold. Please see section 3.4.7 of the full guideline for further information on the committee's deliberations. Wet nappies are one of the many signs of dehydration, and an obvious one for carers to monitor, however, a reduction in wet nappies would not be the sole criteria for onward referral.
23	SH	Royal College of Paediatrics and Child Health	10	Full	2.2	20	Point 17- "When deciding whether to admit a child with bronchiolitis, take account of the following risk factors for more severe bronchiolitis....". Should this say "When deciding whether to admit a child with bronchiolitis who does not fulfil the criteria above (i.e. in point 16), take account of the following risk factors for more severe bronchiolitis...."- Point 17 (& 18) are essentially reasons for admitting an infant who currently doesn't fulfil the criteria for admission but is at high risk for deterioration and thus admission in the (near) future. We don't think the distinction between point 16 with 17 & 18 are clear enough at present.	Thank you for your comment. Recommendation 16 has been removed and recommendations 17 & 18 have been updated following stakeholder consultation.
24	SH	Royal College of Paediatrics and Child Health	11	Full	2.2	21	Point 20- criteria for discharge says "adequate oral intake" but gives no percentage of usual- again slightly contradictory to the definite <75% requiring admission.	Thank you for your comment. The committee consider that clinicians should use their clinical judgement in determining whether fluid intake is adequate. At the point of discharge the clinical considerations are often different

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								to those for the child first presenting with bronchiolitis. Many will be showing signs of clinical improvement.
25	SH	Royal College of Paediatrics and Child Health	12	Full	2.2	21	Says "Measure **pulse** oxygen saturation using pulse oximetry in every child....." presumably should read "Measure oxygen saturation using pulse oximetry in every child..."	Thank you for your comment. This has been corrected.
26	SH	Royal College of Paediatrics and Child Health	13	Full	2.2	21	Currently: Point 28- Do not do CXR in children with bronchiolitis.... Point 29- Do not routinely carry our blood gas... Point 30- Consider doing a blood gas if.... Should Point 28 be "Do not routinely do CXR...." and then the next point be "Consider CXR if...." (same reasons as for doing a blood gas i.e. >50% O2 or impending resp failure, or atypical presentation- may not decide need for antibiotics but may be required to rule out other diagnoses in a child with severe resp failure e.g. pneumothorax, congenital abnormality, cardiac failure etc and if they're about to go to PICU you'll certainly want a CXR)	Thank you for your comment. The term 'routinely' has been added to the existing recommendation and we have added a new recommendation on when a chest x-ray should be considered as suggested.
27	SH	Royal College of Paediatrics and Child Health	14	Full	2.2	22	Point 34- re: bronchodilators- as per my point 3 above	Thank you for your comment. The small number of babies that would benefit from this do not have bronchiolitis and are therefore outside of the scope of the guideline.
28	SH	Royal College of Paediatrics and Child Health	15	Full	2.4	25	The Care Pathway: This is very unclear. Is it aimed at primary care or secondary care or both? We presume both - if so in the 2 boxes where is says definitely refer/consider referring it should say who to (i.e. hospital).	Thank you for your comment. The care pathway has been updated following stakeholder consultation and any revisions made to the recommendations. The care pathway is aimed at both primary and secondary care. We have clarified where the child has been

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							lso some of the points on the pathway are different from the bullet point recommendations e.g. feeding <75% is consider referral (to hospital?) in the pathway but a definite hospital admission criteria in the text. If an infant goes to their GP with only 70% feeding and no resp distress they will be discharged home with advice but if they attend A&E they will be admitted? First box (top left hand corner) should have some mention of considering the diagnosis of bronchiolitis if there's apnoea in a small infant. From that box follow the No path to consider alternative diagnosis. If yes- manage appropriately (I agree), if No then go home- this doesn't seem to make sense. If No (then you have in fact diagnosed bronchiolitis) you should move to the Yes box coming out from the first box (top left hand corner) and continue the algorithm from there. Follow the Yes path from the first box- we are unclear from this point. We think this is the move from primary care to secondary care. The boxes are repetitive and unclear about criteria for referral to hospital for assessment and then, after assessment in hospital the criteria for admission/considering admission. I think this needs to be much clearer. In the box mentioning impending resp failure- should be a consideration of referral to local	referred. The committee did not agree to go into the level of detail that you request as that would be a reproduction of the recommendations. This has been updated to clarify that children with bronchiolitis need to be assessed. This has been updated to clarify difference between referral and admission to hospital clearer. Regarding your other comments, the committee did not agree to go into the level of detail that you request as that would be a reproduction of the recommendations. Please note that

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							HDU/PICU (as well as trial of CPAP) Other comments on the pathway: - The first box on the top left would benefit from an age range, i.e. <2y and more common <1y - Underneath 'consider alternative diagnosis' it may be worthwhile mentioning the most common differentials, e.g. pertussis, pneumonia, … - Agree with the 2 arrows following the YES - very confusing - I wonder whether it needs the tertiary care bit (2nd box from bottom) as this is very poorly defined - Bottom box: a 4 hour window with Sats >92% seems at least for some children not enough- maybe could say AT LEAST 4 hours with sats >92% inc sleep.	NICE pathways will be published as part of this guideline, which will link to a range of guidance from NICE, including quality standards, technology appraisals, clinical, public health and social care guidelines and NICE implementation tools.
29	SH	Royal College of Paediatrics and Child Health	16	Full	3.1.3	26	Says "no studies were identified on the age at which bronchiolitis typically occurs" but the following table has a study (Tsolia et al) in that section? In Table 3 there are a couple of typos- RSC+ instead of RSV+.	Thank you for your comment. This section has now been amended.
30	SH	Royal College of Paediatrics and Child Health	17	Full	3.1.5	29	"General appearance" is not a symptom/sign. Do you mean "poor general appearance"? Same comment for section 3.1.7.2.	Thank you for your comment. We have revised accordingly.
16	SH	Royal College of Paediatrics and Child Health	3	Full	4.2.4	198 onwards	We do not understand the apparently redacted segment on p 208 regarding HS vs usual care. It is that there is a fall in length of stay, although the quality of the evidence is low? If we accept that there may be a reduction of length of stay – as per the outcome of the review	Thank you for your comment. At the time of going to consultation this data had not been published and was therefore confidential. It will be visible in the published guideline. The evidence included in the guideline on the effectiveness of hypertonic saline does

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							(although redacted) then a specific hospital deciding to offer nebulised HS to all admitted patients may have benefit. This will obviously not result in a reduction in admissions – since the admission itself has already been determined. It seems to us that in a busy hospital, with limited bed stock, it may make reasonable clinical and financial sense to allow a treatment which is likely to reduce length of stay. We cannot understand the final conclusion in 4.2.4.8 from the rest of the work.	not support recommending its use.
31	SH	Royal College of Paediatrics and Child Health	18	Full	4.2.4.5	208	HS vs. usual care- for some reason this section has been redacted!	Thank you for your comment. At the time of going to consultation this data had not been published and was therefore confidential. It will be visible in the published guideline.
14	SH	Royal College of Paediatrics and Child Health	1	Full	General	General	Overall a good refelction of the current evidence and best practice; however, admission in those taking <75% of usual requirement will massively increase our admission rate. Our current practice is to admit those with the other criteria and / or <50% (not <75%) There is no evidence base to suggest a change from this.	Thank for your comment. The recommendations concerning feed volume have been updated following stakeholder consultation to include a range of 50% - 75% as a threshold. Please see section 3.4.7 of the full guideline for further information on the committee's deliberations.
33	SH	Royal College of Paediatrics and Child Health	20	Full	General	General	-What if neonate with clear bronchiolitis and fever- need to do LP/start antibiotics? Evidence for/against- maybe reference the feverish child NICE guideline (lots of juniors ask about this)	Thank you for your comment. The guideline indicates factors that may suggest a diagnosis of pneumonia in recommendation 1.1.7. Management of pneumonia is outside the scope of the guideline. The Feverish illness in children guideline is listed under "Related NICE guidance" in section 3.2

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								of the NICE guideline
34	SH	Royal College of Paediatrics and Child Health	21	Full	General	General	Shame there are no recommendations around the need for viral testing or cohorting inpatients.	Thank you for your comment. Viral testing and cohorting inpatients are outside of the scope of this guideline.
35	SH	Royal College of Paediatrics and Child Health	22	Full	General	General	Overall this looks great and should deal with a lot of myths with regard to treatment. The only thing we could not work out was whether 0.9% saline is useful or not.	Thank you for your comment. The effectiveness of normal saline was outside of this guideline scope.
15	SH	Royal College of Paediatrics and Child Health	2	NICE	General	General	A very clear document. It would have been helpful to have some of the nuance of role of additional treatments (hypertonic saline, bronchodilators) in subgroups put into the recommendations, although we recognise this is difficult to word.	Thank you for your comment. No evidence was identified for this.
32	SH	Royal College of Paediatrics and Child Health	19	NICE	General	General	Same comments on recommendations as for full version.	Thank you for your comment. Please see our responses to your comments on the recommendations.
107	SH	Royal College of Pathologists	2	Full	4.2	General	There is no consideration of use of ribavirin at all in treatment – is there no role under any circumstances?	Thank you for your comment. The use of ribavirin is outside the scope of the guideline.
106	SH	Royal College of Pathologists	1	Full	General Section 3	General	'Diagnosis' in the document refers only to clinical diagnosis. There is nothing about viral diagnostics other than a passing mention in 'why this guideline is needed': we thought there should be some (sub)section on this aspect, on appropriate tests to be used in what circumstances	Thank you for your comment. Viral diagnostics is outside the scope of the guideline.

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