National Institute for Health and Care Excellence

Bronchiolitis
Scope Consultation Table
25 January - 22 February 2013

	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
1.	SH	**AbbVie**	1	3.1 b)	AbbVie suggests adding the following wording (highlighted in blue) at the end of the sentence (section 3.1 b): "*Symptoms are usually mild and might only last for a few days, but in some cases the disease can cause severe illness"* requiring hospital admission. Occasionally, bronchiolitis can be a life-threatening illness.	Thank you for the suggested wording. However, we do not feel this change would improve the sentence and therefore it has not included.
2.	SH	**AbbVie**	2	3.1 d)	*"There are several individual and environmental risk factors that put infected infants at increased risk of severe illness. These include premature birth, congenital heart disease, cystic fibrosis and immunodeficiency."* Despite referring to environmental risk factors, this section seems to highlight only some of the clinical risk factors known to predispose infants to a high risk of hospitalisation due to severe RSV infection. For example, infants with chronic lung disease (CLD) (formerly known as bronchopulomnary dysplasia - BPD) are deemed to be at high risk of severe RSV hospitalisation, but are not mentioned (The Impact RSV study group, 1998). In addition, the association of variety of nonmedical, environmental, host-related factors with the risk of severe RSV hospitalisation have been extensively researched in pre-term infants. Epidemiologic data suggest that in 33-35 wGA subjects RSV infection is more likely to lead to hospitalisation when the following risk factors are present (OR, 95% CI): absolute chronologic age at the start of RSV season ≤ 10 weeks (3.95; 2.65-5.90), breast-feeding ≤ 2 months (3.26; 1.96-5.42), ≥ 1 school age siblings (2.85; 1.88-4.33), ≥ 4 residents/visitors at home (1.91; 1.19-3.07) and history of wheezing in the family (1.90; 1.19-3.01)	Thank you for your comment. We agree that we should mention some of the environmental factors here and this change has been made.

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					(Simoes 2003, Simoes et al 1993, Stensballe et al 2006 and Figueras-Aloy 2004). The probability of having an RSV-LRTI increases with combinations of risk factors. The presence of two risk factors in an infant may increase the probability of RSV-related hospitalisation by at least 3.6 times compared to an infant 33-35 weeks GA without risk factors (Carbonell-Estrany 2004). AbbVie therefore wishes that a comprehensive list of the clinical and environmental risk factors increasing the risk of- and severity of RSV infection is provided.	
3.	SH	**AbbVie**	3	3.2 e)	*"In some locations children with risk factors for severe bronchioloitis may be offered immunoprophylaxis with intramuscular palivizumab."* AbbVie suggests removing the words *"in some location".* As per current national Clinical Commissioning Policy for palivizumab prepared by the NHS Commissioning Board Clinical Reference Group (CRG) for Neonatal Intensive Care "Palivizumab to Reduce the Risk of Respiratory Syncytial Virus (RSV) in High Risk Infants", palivizumab will be routinely commissioned for the prevention of RSV infection in all infants who meet the stated patient selection criteria (please refer to the aforementioned clinical commissioning policy for further details).	Thank you for your comment. This section describes current practice and the statement reflects the reality of provision. Therefore, this will not be changed.
4.	SH	**AbbVie**	4	4.1.1b)	*Groups that will be covered by the guidelines: "subgroups of infants with preterm birth, congenital heart disease, cystic fibrosis and immunodeficiency."* AbbVie believes that the following subgroups of infants should also be added to the guideline scope: infants with chronic lung disease (please refer to the comment number 2), infants with Down syndrome (Bloemers et al 2007), neuromuscular/metabolic disorder (Handforth et al 2000), infants undergoing chemotherapy or bone-marrow and/or solid organ transplant (Simoes 2000).	Thank you for your comment. The sub-groups listed were examples of those that will be addressed in the guideline. The wording of this statement has been amended to clarify this. *"Patient subgroups will be identified based on the available evidence, for example: premature birth, congenital heart disease, cystic fibrosis,*

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						immunodeficiency and chronic lung disease."
5.	SH	**AbbVie**	5	4.1.2 b)	*"Groups that will not be covered: infants being cared for on neonatal units"* It is unclear why the scope of the guideline excludes infants being cared for on neonatal units while it aims to cover subgroups of infants with preterm birth, congenital heart disease, cystic fibrosis and immunodeficiency. It is well-known that the aforementioned infant subgroups are frequently long-term residents on neonatal wards during the RSV season because of chronic respiratory problems. Further, conventional infection control measures often fail to prevent the spread of RSV in hospital settings rendering these vulnerable infants at risk of nosocomial infection. Whilst it is recognised that RSV frequently causes nosocomial outbreaks in general paediatric wards, occasionally, it also known to do so in neonatal wards (Kurz et al 2008, Bont 2009). Therefore, given that the guidelines already aim to cover infants with preterm birth, congenital heart disease, cystic fibrosis and immunodeficiency AbbVie considers that for completeness, the guidelines should also include infants cared for on the neonatal units.	Thank you for your comment. There were several stakeholder comments asking for neonatal and intensive care units to be covered by the guideline. After discussion this change has been agreed and the exclusion has been removed. The guideline will focus on the indications for using investigations, treatments and support methods, but without specifying where these are provided. However, the guideline will not cover infection control measures or viral testing. These relate to prevention of disease and wider hospital management, which are beyond the remit for the guideline. NICE has also produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated

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						infection in primary and community care http://guidance.nice.org.uk/PH36
6.	SH	**AbbVie**	6	4.3.2 b)	*"Clinical Issues that will not be covered: prevention of viral transmission in hospital, such as viral testing"* It is unclear why the guideline development group decided to exclude etiologic, in hospital testing as means of prevention of viral transmission and potentially successful differentiation of bronchiolitis from other respiratory conditions. Study by Flaherman et al (2010) found that among hospitalised infants, the use of antibiotics was significantly lower among those with a positive RSV test than those with negative RSV test suggesting that the knowledge gained from testing has the potential to inform clinician prescribing behaviour, management decisions and subsequently outcomes of children with clinically diagnosed bronchiolitis. AbbVie therefore believes that the inclusion of testing would aid successful diagnosis, prognosis and treatment of infants diagnosed with bronchiolitis. Further, testing could help optimise antibiotics prescribing for children with bronchiolitis; it could help manage in-hospital cohorting and bed assignment; it would aid the Health Protection Agency in RSV surveillance determining the onset and offset of RSV season and it would contribute towards further understanding of the epidemiology of RSV bronchiolitis in the UK.	Thank you for your comment. A number of stakeholders have raised questions about the use of viral testing. Whilst we agree these are important, viral testing is beyond the remit of this guideline as it relates to prevention of disease. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by this guideline. NICE has also produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36

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7.	SH	**AbbVie**	7	4.3.2 f)	*"Clinical Issues that will not be covered: prevention of bronchiolitis by the use of palivizumab for immunoprophylaxis of RSV (there are existing guidelines from Joint Committee on Vaccination and Immunisation on this)"* The draft scope directs the reader to the Joint Committee on Vaccination and Immunisation (JCVI) recommendations on palivizumab use, however AbbVie wishes to highlight that there is a more recent national policy on palivizumab prescribing produced by the NHS Commissioning Board Clinical Reference Group (CRG) for Neonatal Intensive Care called "Palivizumab to Reduce the Risk of Respiratory Syncytial Virus (RSV) in High Risk Infants" (please refer to our comment 3). As this policy represents the most recent NHS recommendation on prophylaxis with palivizumab, AbbVie wishes it is also referenced in this section.	Thank you for your comment. We have not added this reference as the JCVI recommendations represents the current clinical guidance in this area. Also, it is the role of the JCVI to provide any future clinical guidance on the use of Palivizumab.
8.	SH	**AbbVie**	8	4.4 b)	*"Health service outcomes: need for referral to secondary care, admission rates, length of treatment, readmission rate"* AbbVie wishes that the following wording is also added to the "*health service outcomes section"*: information on prevention strategies should be communicated to parents of children affected by bronchiolitis.	Thank you for your comment. This section relates to the outcome measures that will be used to judge benefit and harms. Therefore, no change will be made.
9.	SH	**Alder Hey Children's NHS Foundation Trust**	1	3.1 (f)	This paragraph reports on mortality caused by bronchiolitis in children up to 14yrs of age. The scope of the guideline is being developed for children less than 2 years of age. I think this paragraph needs to reflect the scope of the guideline and specify the mortality rate in infants and children up to 2yrs of age.	Thank you for your comment. This is the age grouping used by Hospital Episode Statistics.
10	SH	**Alder Hey Children's NHS Foundation Trust**	2	3.2 (b)	Define the following: i) 'moderate or severe' respiratory distress ii) reduced oxygen saturation iii) Apnoea	Thank you for your comment. This section provides a brief summary of the epidemiology and management

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					iv) poor feeding v) diagnositic uncertainty	of the condition, so detailed descriptions are not provided. However, when guideline development begins these items will be defined in detail and published in the full version of the final guideline.
11	SH	**Alder Hey Children's NHS Foundation Trust**	3	3.2 (c)	Define 'mild & moderate'	Thank you for your comment. This section provides a brief summary of the epidemiology and management of the condition, so detailed descriptions are not provided. However, when guideline development begins 'mild & moderate' will be quantified and this definition will be published in the full version of the final guideline.
12	SH	**Alder Hey Children's NHS Foundation Trust**	4	3.2 (d)	Not all infants admitted to hospital are severe	Thank you for your comment. We agree, this section relates to the treatment that may be given to those with severe symptoms who have been hospitalised.
13	SH	**Alder Hey Children's NHS Foundation Trust**	5	3.2 (f)	Do you need to include recurrent wheeze here also?	Thank you for your comment. Recurrent wheeze/early asthma is a condition in itself, whereas this statement relates to post-bronchiolitis symptoms caused by bronchiolitis.

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						Therefore, to avoid any potential confusion this term will not be added.
14	SH	**Alder Hey Children's NHS Foundation Trust**	6	4.1.2 (c)	Does this need to be changed to infants receiving IPPV? As ncpap/hiflow oxygen is covered and they may be looked after on a PICU	Thank you for your comment. Several stakeholders have highlighted this inconsistency. Therefore, infants treated on PICU will now be covered by the guideline.
15	SH	**Alder Hey Children's NHS Foundation Trust**	7	4.3.1 (c)	Should the following treatment interventions be included here; i) 0.9% saline nebulisers ii) 0.9% saline nasal drops	Thank you for your comment. The inclusion of these treatments was discussed. It is realised that these are commonly used over-the-counter treatments. It is also known that RCTs of hypertonic saline often use normal saline as a comparator. However, it was concluded that they are rarely used in clinical practice and that the main clinical question relates to the use of hypertonic saline. Therefore, they were not added as treatments to be examined.
16	SH	**Alder Hey Children's NHS Foundation Trust**	8	4.3.1 (d)	Should the following supportive measures be included here; i) Suctioning ii) Positioning	Thank you for your comment. A question on 'use of nasal suction' has been added to list of topics that will be covered by the guideline. Positioning of infants will not be

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						examined as it is not a commonly used strategy and this could potentially contradict more general advice that infants should be placed on their backs to reduce the risk of sudden infant death syndrome.
17	SH	**Alder Hey Children's NHS Foundation Trust**	9	4.4 (a)	Should adverse effects and burden of illness be included here?	Thank you for your comment. Adverse effects and burden of disease (quality of life) will be assessed.
18	SH	**Alder Hey Children's NHS Foundation Trust**	10	4.4 (b)	Should economic outcomes be included here?	Thank you for your comment. Economic outcomes are based on QALYs which in turn are based on quality of life data.
19	SH	**Alder Hey Children's NHS Foundation Trust**	11	4.5.2 (f)	What is the efficacy of 0.9% saline nebulisers? What is the efficacy of 0.9% saline nasal drops?	Thank you for your comment. The inclusion of these treatments was discussed. It is realised that these are commonly used over-the-counter treatments. It is also known that RCTs of hypertonic saline often use normal saline as a comparator. However, it was concluded that they are rarely used in clinical practice and that the main clinical question relates to the use of hypertonic saline. Therefore, they were not added as treatments to be examined.

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20	SH	**Alder Hey Children's NHS Foundation Trust**	12	4.5.3 (f)	What is the efficacy of suctioning? What is the efficacy of positioning?	Thank you for your comment. A question on 'use of nasal suction' has been added to list of topics that will be covered by the guideline. Positioning of infants will not be examined as it is not a commonly used strategy and this could potentially contradict more general advice that infants should be placed on their backs to reduce the risk of sudden infant death syndrome**.**
21	SH	**Alder Hey Children's NHS Foundation Trust**	13		Infection control guidance needs to be included i) Cohorting ii) Cubicalisation iii) NPA/PCR testing	Thank you for your comment A number of stakeholders have raised questions about the use of viral testing for cohorting and preventing the spread of bronchiolitis. Whilst we agree these are important, questions relating to cohorting and prevention are beyond the remit of this guideline. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by this guideline. NICE has also produced a quality improvement guideline on the

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						prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36
22	SH	**Alder Hey Children's NHS Foundation Trust**	14		Guidance on referral to PICU/HDU	Thank you for your comment. Several stakeholders have highlighted admission to PICU/HDU are often determined by where treatment and support is provided. Therefore, the restriction has been removed and the guideline will provide guidance on the indications for use of treatment and support rather than to where these are provided.
23	SH	**Alder Hey Children's NHS Foundation Trust**	15		Guidance on what information to give parents on home management and how to help them decide when to seek further medical help	Thank you for your comment. Information for parents on when to seek help will be based on the results of reviews on symptoms, signs and risk factors.
24	SH	**Alder Hey Children's NHS Foundation Trust**	16		Public health information raising awareness of this condition amongst parents/carer's prior to getting illness eg antenatal information	Thank you for your comment. NICE provide implementation toolkits to help health professionals and patients. However, explicit recommendations on public health

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						information are usually beyond the remit of NICE clinical guidelines, and there are no plans to cover this issue in this guideline.
25	SH	**Alder Hey Children's NHS Foundation Trust**	17	Page 4 4.3.1	Add indication for cap gas	Thank you for your suggestion. This question will be added to the list of topics covered by the guideline.
26	SH	**Alder Hey Children's NHS Foundation Trust**	18	GENERAL	A bit surprised that there was no mention of nasopharyngeal suctioning or feeding management within the guideline development scope. Suctioning is a key part of airway management in clinical practice, in my experience removal of excess secretions can enhance breathing and oral feeding and fits with two of the three goals of the bronchiolitis pathway management (within the bronchiolitis pathway we use at alder hey) which are "prevention of dehydration and to maintain satisfactory oxygen saturation". The pathway indicates suctioning should only be used when secretions are blocking the nose. Within the pathway on the fluid balance chart there is also space to record when suction has been performed. The pathway contains a comprehensive feeding management flow chart. Having used the pathway for many years I feel that this has greatly enhanced and standardised care and practice in relation to management of children with bronchiolitis.	Thank you for your comment. A question on 'use of nasal suction' has been added to list of topics that will be covered by the guideline. Similarly, the indications for feeding support will be examined.
27	SH	**British Paediatric Respiratory Society and British Thoracic**	1	Title	The title was felt to be ambiguous and to raise the possibility of confusion with obliterative bronchiolitis. One suggestion was to use the title "infectious bronchiolitis in young children"	Thank you for your comment. This suggested change was discussed. It was decided not to

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		Society				change the title as it was not believed that readers would confuse the guideline for one on obliterative bronchiolitis.
28	SH	**British Paediatric Respiratory Society and British Thoracic Society**	2	4.1	We feel it is important that environmental / social factors such as breast-feeding and particularly ETS needed to be adequately covered by the guideline (in both population and "risk factors for severe bronchiolitis" sections).	Thank you for your comment. Environmental factors will be examined in relation to risk-factors for developing severe bronchiolitis. This is outlined in section 4.5.1.
29	SH	**British Paediatric Respiratory Society and British Thoracic Society**	3	4.1.1	We felt concerned about the upper age limit of 2. It was felt that this would undoubtedly include a number of patients with viral induced wheeze. It was felt that, if this age limit was used, then it would be important to explore the differential diagnosis adequately, particularly in those between 1 and 2 years of age.	Thank you for your comment. The scope is no longer restricted by age.
30	SH	**British Paediatric Respiratory Society and British Thoracic Society**	4	4.2	It was felt that intensive care management **should** be part of the scope and that IV Ribavirin be included in the treatments covered.	Thank you for your comment. There were several stakeholder comments on this issue. After discussion it has been decided that this restriction will be removed, and neonatal and intensive care units will be covered by the guideline. It is not possible for the guideline to cover all aspects of management. Therefore, as ribavirin is an existing treatment that is rarely used in the UK

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						it was decided that the resources of the guideline will be focused on other issues.
31	SH	**British Paediatric Respiratory Society and British Thoracic Society**	6	4.3.2	It was felt that in-hospital viral testing (including cohorting implications) should be covered in the guideline	Thank you for your comment. A number of stakeholders have raised questions about the use of viral testing. Whilst we agree these are important, viral testing for cohorting and disease prevention is beyond the remit of this guideline. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by this guideline. NICE has also produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36
32	SH	**British Paediatric**	7	4.3.2	The membership believe that the use of montelukast should be	Thank you for your comment.

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		Respiratory Society and British Thoracic Society			covered in the treatment section particularly given the conflicting nature of the published data.	As Montelukast is a new treatment that is increasingly being used in UK practice it will be added to the list of treatments covered by the guideline.
33	SH	**Department of Health**	1	General	A very important omission is the complete absence of mention of tobacco smoke - exposure at home and in utero, and relevance for prevention and management of bronchiolitis.	Thank you for your comment. Environmental factors will be examined in relation to risk-factors for developing severe bronchiolitis. This is outlined in section 4.5.1.
34	SH	**Department of Health**	2	General	Also missing is the investigation of slowly resolving bronchiolitis - who and when to investigate - e.g. HIV or other immunodeficiency, CF, ILD.	Thank you for your comment. The guideline will include all the main investigations for monitoring the progression and severity of bronchiolitis. However, no specific question 'slow resolving bronchiolitis' has been outlined.
35	SH	**Healthcare Infection Society**	1	4.1.1 b)	The wording of this section may be following NICE editorial standards, in which case I apologise. However, as it reads it sound almost that the guidance will be restricted to these patients groups. I wonder if it would be better to refer to these groups using the terminology already used in 3.1 d) – i.e. at increased risk of severe illness.	Thank you for your comment. The guideline will not be restricted to these groups. Instead this sentence is meant to highlight that important sub-groups will not be left out. The section has been amended to read: *"Patient subgroups will be identified based on the available evidence, for example: premature birth, congenital*

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						heart disease, cystic fibrosis, immunodeficiency and chronic lung disease."
36	SH	**Healthcare Infection Society**	2	4.3.1 a)	I am disappointed to see that the use of microbiological diagnostic tests has not been included in this section, given that there is enormous variation in practice between hospitals in how patients are investigated. Whilst I accept that there may be a lack of good quality research around some aspects of this, there are studies examining the sensitivities of different diagnostic strategies. There are important considerations here, such as when it is not necessary to test at all, when (if ever) confirming a viral aetiology can help to determine clinical decision making (e.g. CXR, antibiotic therapy), when it may be important to test specifically for influenza viruses.	Thank you for your comment. Whilst we agree these are important questions, microbiological diagnostic tests are undertaken when bacterial illness is suspected rather than bronchiolitis. Unfortunately, this is beyond the remit of this guideline. Viral testing is undertaking to allow cohorting and prevent the spread of bronchiolitis, which is also beyond the remit of the guideline. Therefore, this issue will not be covered by the guideline.
37	SH	**Healthcare Infection Society**	3	4.3.1 b)	Again, I would like to see the scope of this broadened to include laboratory investigations. Many patients who present to secondary care get a battery of investigations, including full blood count, biochemistry, blood cultures etc. Would be helpful to define when these investigations are indicated.	Thank you for your comment. Whilst we agree these are important questions, full blood count, biochemistry and blood cultures are undertaken to identify bacterial illness, and unfortunately this is beyond the remit of this guideline. Therefore, this issue will not be covered by the guideline. The guideline will focus on tests commonly used to monitor the severity

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						of bronchiolitis.
38	SH	**Healthcare Infection Society**	4	4.3.1 c)	I don't think that antibiotics should be listed as a treatment for bronchiolitis, because they are a treatment for a complication of bronchiolitis.	Thank you for your comment. Antibiotics are often used to treat bronchiolitis rather than complications caused by bronchiolitis. Therefore, the guideline will examine the effectiveness of this treatment.
39	SH	**Healthcare Infection Society**	5	4.3.2 b)	I can understand why you have chosen not to cover prevention of viral transmission in hospitals. However, the final phrase 'such as viral testing' does not really make sense: I suggest that this phrase should be deleted, or it needs to be expanded slightly to something like 'such as viral testing to determine placement of patients admitted to hospital.'	Thank you for your comment. This has been amended to read: "Viral testing in hospital to prevent transmission."
40	SH	**Healthcare Infection Society**	6	4.5.2 b)	I suggest that this sentence might be better if worded along the lines of the sentence in 4.5.1 f) on use of radiology, e.g. 'What are the indications for commencing antibiotic therapy in bronchiolitis?'	Thank you for your comment. These are currently draft review questions and will be refined and confirmed by the GDG therefore the wording may be changed.
41	SH	**Neonatal & Paediatric Pharmacists Group**	1	4.1.2 a	Given the difficulty in differentiating bronchiolitis from other conditions it is surprising that infants with viral wheeze are not to be covered by the guideline. This seems to be at odds with 4.3.1.	Thank you for your comment. The remit for the guideline sent by the Department of Health is the management of bronchiolitis. Therefore, it cannot be extended to cover viral wheeze. However, the guideline will examine how bronchiolitis is differentiated from other conditions, such as viral wheeze.
42	SH	**Neonatal &**	2	4.1.2 c	In view of the fact that some infants with bronchiolitis may have severe	Thank you for your comment.

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		Paediatric Pharmacists Group			enough symptoms to warrant admission to Paediatric Intensive care (PICU), it is disappointing that this group is not to be covered by the guideline.	There were several stakeholder comments on this issue. After discussion it has been decided that neonatal and intensive care units will be covered by the guideline. The guideline will focus defined investigations, treatments and support methods, but will not specify where these are provided.
43	SH	**Neonatal & Paediatric Pharmacists Group**	3	4.3.1	Please ensure that all strengths of hypertonic saline are covered including 3%, 6% and 7%. There are a number of other possible interventions which are not mentioned including ribavirin nebulised and intravenous (see below), use of surfactants and dornase alfa. Many of these may be considered in infants who are admitted to PICU (see above)	Thank you for your comment. The strengths of hypertonic saline covered by the guideline will be determined by the available evidence. Neither ribavirin nor surfactants will be covered by the guideline. The reason for this is that they are rarely used in UK practice.
44	SH	**Neonatal & Paediatric Pharmacists Group**	4	4.3.2	We are concerned that ribavirin is not being covered in this guidance. In addition, whilst we are aware that JCVI guidelines exist on the use of palivizumab for prophylaxis of RSV, these guidelines are vague and practice across the UK still varies. This would be an ideal opportunity for the prophylaxis guidance to be revisited.	Thank you for your comment. Guidance on the use of palivizumab comes under the remit of the JCVI, so it cannot included in this guideline.
45	SH	**Neonatal & Paediatric Pharmacists**	5	General	In view of the potential problems in diagnosis of bronchiolitis, it may be worth considering a broader title for this guidance.	Thank you for your comment. This suggested change was

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		Group				discussed. It was decided that the title would not be changed, so that the reader is clear that this is a guideline on bronchiolitis.
46	SH	**NHS Direct**	1		NHS Direct have considered the scope and have no comments on its content.	Thank you for taking the time to read the draft scope.
47	SH	**NHS Sheffield**	1	4.1.1	This looks good. It would help to consider the longer term consequences of bronchiolitis.	Thank you for your comments. Long-term outcomes are outlined in section 4.4a
48	SH	**NHS Sheffield**	2	4.3.2 (f)	It is a shame that immunisation is specifically excluded as the appropriate use of pavilizumab would potentially influence the management of some of the at risk children	Thank you for your comment. Guidance on the use of palivizumab comes under the remit of the JCVI, so it cannot included in this guideline.
49	SH	**Paediatric Intensive Care Society**	1	general	We are disappointed that the scope of the guideline does not include the important aspect of use of CPAP and non-invasive ventilation which is an aspect that is currently poorly defined and yet being used in many UK hospitals in a non-standardised way. In addition we feel that the use of high flow, high humidity oxygen delivery systems should be included – again in wide spread use and uncontrolled or standardised. We would also suggest that it would be imperative to have a paediatric intensivist on the guideline development group. After all they, along with general paediatricians, will manage the most severe cases – respiratory paediatricians will generally not be involved in management of acute bronchiolitis.	Thank you for this comment. CPAP is included in the section 4.3.1. The exact wording of the review question will be determined by the GDG. A paediatric intensivist will be invited to be an expert advisor for the guideline.
50	SH	**Royal College of General Practitioners**	1	"General"	IW - I would agree with the scope as it is, and consider it would be of value to the diagnosis and management of bronchiolitis in Primary Care	Thank you for your comment and taking the time to read the draft scope.
51	SH	**Royal College of**	2	3.2b)	JA - other conditions (such as cerebral palsy, congenital	Thank you for your comment.

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		General Practitioners			abnormalities of upper respiratory tract etc can mean that bronchiolitis is particularly severe - perhaps a more inclusive term under b could be used?	The sub-groups listed were examples of those that will be addressed in the guideline. The wording of this statement has been amended for clarity. "*Patient subgroups will be identified based on the available evidence, for example: premature birth, congenital heart disease, cystic fibrosis, immunodeficiency and chronic lung disease."*
52	SH	**Royal College of Nursing**	1	General	The Royal College of Nursing welcomes proposals to develop this guideline for the management of the condition referred to as bronchiolitis, where it is recognised that this infection only rarely causes death in otherwise well infants and young children. The misery, morbidity and the cost to the health services of the condition means that greater understanding and improved management is required.	Thank you for your comment and taking the time to read the draft scope.
53	SH	**Royal College of Nursing**	2	3.1.d	Environmental risk factors include exposure to parental smoking /second-hand smoke, low birth weight, crowded living conditions, including attendance at nursery/day care. Also chronic lung disease, particularly bronchopulmonary dysplasia	Thank you for your comment. Environmental factors will be examined in relation to risk-factors for developing severe bronchiolitis.
54	SH	**Royal College of Nursing**	3	3.1.g	It is also associated with an increase of respiratory symptoms and reactive airways disease	Thank you for your comment. The GDG will determine which outcomes are assessed, and this may

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						include prevalence of long-term respiratory problems.
55	SH	**Royal College of Nursing**	4	3.2 a	While it is accepted that the GPs have a central role in the assessment of infants and young children to ascertain the diagnosis, the attendance of a sick infant to the GP's surgery is fraught with the risks of spreading the disease. Consideration needs to be given to holding the coughs and sneezes' appointments away from general sitting and waiting areas or at the very end of the appointment day.	Thank you for your comment. Prevention of bronchiolitis is beyond the remit of the guideline. Furthermore, it is felt the question raised here goes far wider than bronchiolitis to general infection control strategies. Therefore, this issue will not be covered by the guideline. NICE has also produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36.
56	SH	**Royal College of Nursing**	5	3.2.c	Though not a therapy but also suggest offering small more frequent feeds as this helps with improved feeding	Thank you for your comment. The guideline will examine indications for feeding support. However, the guideline will not examine the efficacy of different feeding strategies these will vary depending on severity of disease and local resources.

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57	SH	**Royal College of Nursing**	6	3.2 c	Are there no studies on the use of humidity and steam to relieve some of the distress and provide symptomatic relief from Bronchiolitis?	Thank you for your comment. Although traditionally used, humidity and steam therapy do not form part of current clinical practice. Therefore, they have not been included in the scope.
58	SH	**Royal College of Nursing**	7	3.2 e	If the development process deems that immunisation is effective, it would be nice to have clear guidelines and recommendations that all high risk ex preterm infants can be protected in this way as presently there is huge variability in practice. Especially in cases where the neonatal network providing the initial care is many miles away from the family GP and when all else is apparently normal infant follow ups can be erratic.	Thank you for your comment. Guidance on immunisation comes under the remit of the JCVI, so it cannot included in this guideline.
59	SH	**Royal College of Nursing**	8	3.2.f	…such as problematic cough and wheeze	Thank you for this suggest wording. We have not changed the text as wheeze may be defined as a separate condition rather than a post-bronchiolitis syndrome, and we do not want to create any confusion.
60	SH	**Royal College of Nursing**	9	3.2.g	Infection is spread by direct contact with respiratory secretions therefore guidance on managing spread of infection and avoidance of exposure to respiratory syncytial virus (RSV) in the first 3 months of life is important	Thank you for your comment. Viral testing and the prevention of bronchiolitis is beyond the remit of this guideline. Furthermore, it is felt this question goes far wider than bronchiolitis to general infection control measures. Therefore, this issue will not be covered by this guideline.

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						NICE has also produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36.
61	SH	**Royal College of Nursing**	10	4.1.1 a	Relevant cohort and sub groups identified.	Thank you for your comment
62	SH	**Royal College of Nursing**	11	4.1.1 b	As in 4.1.1 a above, and also chronic lung disease	Thank you for your comment. The sub-groups listed were examples of those that will be addressed in the guideline. The wording of this statement has been amended for clarity. *"Patient subgroups will be identified based on the available evidence, for example: premature birth, congenital heart disease, cystic fibrosis, immunodeficiency and chronic lung disease."*
63	SH	**Royal College of Nursing**	12	4.1. 2 b-c	a) Unless testing is done how will it be identified that children with recurrent cough/ wheeze are not those with post viral bronchiolitis airway irritation and other conditions?	Thank you for your comment. A number of stakeholders have raised questions about the use of viral

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					It is a pity that this is excluded as general guidelines need to be available to guide practice in NNU and CICU particularly with regards to the principles of isolation, cohort nursing, infection control, restricted visiting, use of viral filters on ambi-bags and ventilators and decontamination.	testing. Whilst we agree these are important, viral testing is beyond the remit of this guideline. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by this guideline. NICE has also produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36
64	SH	**Royal College of Nursing**	13	4.1.2 c	This needs to be clearer with regards to PICU as some hospitals will admit children requiring CPAP or HFOV to PICU as they do not have a safe HDU to nurse them so maybe this could be rephrased to "children requiring invasive ventilation will not be included"	Thank you for your comment. We have received several comments on this issue and it has been decided to remove the exclusion of neonatal and intensive care units from the guideline. The guideline will focus on indications for investigations and treatments rather than where these are undertaken.

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65	SH	**Royal College of Nursing**	14	4.3.1 a	Consider including apnoea, pyrexia dehydration and feeding issues	Thank you for comment. The final list of symptoms that are reviewed will be determined by the GDG, but those mentioned here will be presented to them for inclusion.
66	SH	**Royal College of Nursing**	15	4.3.1 a	Will this consider the effectiveness and advantages of RSV rapid testing kits? May help with cohorting/early diagnosis out of hours	Thank you for your comment. A number of stakeholders have raised questions about the use of viral testing. Whilst we agree these are important, however, viral testing and prevention of bronchiolitis are beyond the remit of this guideline. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by this guideline. NICE has also produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36

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67	SH	**Royal College of Nursing**	16	4.3.1. b	Not recommended for primary care but investigations for consideration in hospital include rapid viral antigen testing of nasopharyngeal secretions for RSV, arterial blood gas (ABG) analysis (in severely ill patients, especially those considered for or requiring mechanical ventilation), full blood count including white blood cell (WBC) count with differential and C-reactive protein (CRP) level. Viral testing for RSV does influence treatment, in that physicians appear to be more likely to withhold antibiotics or to stop them sooner in patients who are RSV-positive. RSV positive infants can also be used to cohort or isolate patients who are RSV-positive	Thank you for your comment. Indications for capillary blood gas testing has been added to the guideline. However, the other tests mentioned have not been included as this related to differentiating viral from bacterial conditions, which is beyond the remit of the guideline. A number of stakeholders have raised questions about the use of viral testing. Whilst we agree these are important, it is beyond the remit of the guideline to examine viral testing and prevention of bronchiolitis. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by this guideline. NICE has also produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated

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						infection in primary and community care http://guidance.nice.org.uk/PH36.
68	SH	**Royal College of Nursing**	17	4.3.1 c	Will the team consider the use of Surfactant as a treatment option?	Thank you for your comment. This issue was discussed but it was concluded that surfactants are a highly specialised treatment that are rarely used. Therefore, they will not be covered by this guideline.
69	SH	**Royal College of Nursing**	18	4.3.1 c & d	It is very important to assess which therapies are of value and which are still given for reasons of whim and the requirement to be seen to be doing something.	Thank you for comment. The aim of this guideline will be to provide evidence recommendations on the diagnosis and management of Bronchiolitis. If un-necessary treatment is being undertaken for bronchiolitis then hopefully this guideline can help reduce this.
70	SH	**Royal College of Nursing**	19	4.3.2	We are sorry to see that prevention of infection in hospitals is excluded. It would also be nice to have the evidence to present to parents that additional vitamin C is beneficial or not and whatever substance was purchased in health shops or was obtained from complementary/ethnic medicine sources were of no proven benefit.	Thank you for your comment. A number of stakeholders have raised questions about the use of viral testing. Whilst we agree these are important, it is beyond the remit of the guideline to examine prevention of bronchiolitis. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this

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						issue will not be covered by this guideline. Similarly, food supplements and alternative therapies do not form part of NHS management, so are beyond the remit of this guideline.
71	SH	**Royal College of Nursing**	20	4.4	The outcomes are all appropriate – comprehensive – the use of validated tools such as PEWS in infants and children with bronchiolitis would be welcome and would fit very nicely in section (a)	Thank you for your comment. Where possible we will use existing validated tools, such as the one mentioned.
72	SH	**Royal College of Nursing**	21	4.5.1	Diagnosis - need to consider/ask when viral testing e.g. nasopharyngeal secretions should be done. Also include what is the efficacy of non-invasive ventilation either here or in supportive treatment of bronchiolitis	Thank you for your comment. A number of stakeholders have raised questions about the use of viral testing. Whilst we agree these are important, viral testing is beyond the remit of the guideline. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by the guideline. The types of ventilation covered by the guideline are outlined in section 4.3.1. of the scope.
73	SH	**Royal College of Nursing**	22	4.5.3	Does CPAP need to be included in this section as a supportive measure?	Thank you for this comment. CPAP is included in the section 4.3.1.

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						The exact wording of the review question will be determined by the GDG.
74	SH	**Royal College of Nursing**	23	General	As NPA/viral testing in hospitals is common practice (in some areas) if this is not mentioned or addressed in more detail as to why it is not being reviewed or recommended then there may be more confusion regarding the current recommended practice. Obviously this should be considered from a cost benefit economic perspective too.	Thank you for your comment. A number of stakeholders have raised questions about the use of viral testing. Whilst we agree these are important, it is beyond the remit of the guideline to examine viral testing and prevention of bronchiolitis. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by this guideline. NICE has produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36
75	SH	**Royal College of Paediatrics and Child Health**	1	General 4.3.2	An aspect of management that could be useful for secondary care is the economics around POCT for RSV and its usefulness. A number of DGHs use it for rapid diagnosis and cohorting of	Thank you for your comment. A number of stakeholders have raised

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					babies in bays/larger cubicles.	questions about the use of viral testing. Whilst we agree these are important, it is beyond the remit of the guideline to examine issues relating cohorting to prevent the spread of bronchiolitis. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by the guideline. NICE has produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36
76	SH	**Royal College of Paediatrics and Child Health**	2	4.3.1	The American Academy of Pediatrics guideline allows discharge of babies at oxygen saturations of 90% or more and a position statement from NICE regarding this (from evidence) would be helpful.	Thank you for your comment. The guideline will examine oxygen saturation levels.
77	SH	**Royal College of Paediatrics and Child Health**	3	General	We are disappointed that the scope of the guideline does not include the important aspect of use of CPAP and non-invasive ventilation which is an aspect that is currently poorly defined and	Thank you for this comment. CPAP is included in the section 4.3.1.

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					yet being used in many UK hospitals in a non-standardised way.	The exact wording of the review question will be determined by the GDG.
78	SH	**Royal College of Paediatrics and Child Health**	4	General	We feel that the use of high flow, high humidity oxygen delivery systems should be included. This is also in widespread use and its use is neither controlled nor standardised.	Thank you for your comment. The types of ventilation covered by the guideline are outlined in section 4.3.1. of the scope.
79	SH	**Royal College of Paediatrics and Child Health**	5	General	We would also suggest that it would be imperative to have a paediatric intensivist on the guideline development group. After all, they, along with general paediatricians, will manage the most severe cases – respiratory paediatricians will generally not be involved in management of acute bronchiolitis.	Thank you for your comment. A paediatric intensivist will be included in the GDG as an invited expert.
80	SH	**Royal College of Paediatrics and Child Health**	6	General	We think the scope should be extended to look at supportive measures in inpatient contexts such as the use of naso-gastric feeding and regimes of feeding practice such as reducing fluid volumes from say 150ml/Kg/day to 100-120ml/Kg/day. It should also look at criteria to judge when it is safe to continue feeds and when IV fluids are indicated and what regime of fluid support is optimal.	Thank you for your comment. A question on 'Indications for feeding support' has been added to the scope. However, the guideline will not cover efficacy of different feeding strategies.
81	SH	**Royal College of Paediatrics and Child Health**	7	Title	The title is felt to be ambiguous and to raise the possibility of confusion with obliterative bronchiolitis. One suggestion is to use the title "infectious bronchiolitis in young children".	Thank you for your comment. This suggested change was discussed. It was decided not to change the title as it was not believed that readers would confuse the guideline for one on obliterative bronchiolitis.
82	SH	**Royal College of Paediatrics and Child Health**	8	4.1	It has been emphasised by a number of BPRS/BTS respondents that environmental / social factors such as breast feeding and particularly ETS need to be adequately covered by the guideline	Thank you for your comment. Environmental factors will be

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					(in both the population and "risk factors for severe bronchiolitis" sections).	examined in relation to risk-factors for developing severe bronchiolitis.
83	SH	**Royal College of Paediatrics and Child Health**	9	4.1.1	A number of BPRS/BTS respondents feel concerned about the upper age limit of 2. It is felt that this would undoubtedly include a number of patients with viral induced wheeze. It is felt that, if this age limit is used, then it would be important to explore the differential diagnosis adequately, particularly in those between 1 and 2 years of age.	Thank you for your comment. The scope is no longer restricted by age.
84	SH	**Royal College of Paediatrics and Child Health**	10	4.2	A number of BPRS/BTS respondents (approximately 60%) feel that intensive care management should be part of the scope and that IV Ribavirin be included in the treatments covered.	Thank you for your comment. There were several stakeholder comments on this issue. After discussion it was agreed this restriction needed to be removed. The guideline will focus defined investigations, treatments and support methods, but will not specify where these are provided. It is not possible for the guideline to cover all aspects of management. As ribavirin is an existing treatment that rarely used in the UK it was decided that the resources of the guideline will be focused on other issues.
85	SH	**Royal College of Paediatrics and**	11	4.3.2	A majority of BPRS/BTS respondents feel that in-hospital viral testing (including cohorting implications) should be covered in	Thank you for your comment.

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		Child Health			the guideline.	A number of stakeholders have raised questions about the use of viral testing. Whilst we agree these are important, it is beyond the remit of the guideline to examine prevention of bronchiolitis. Furthermore, it is felt this question goes far wider than viral testing, to hospital-wide infection control measures. Therefore, this issue will not be covered by this guideline. NICE has also produced a quality improvement guideline on the prevention and control of healthcare-associated infections, available from http://guidance.nice.org.uk/PH36 and a clinical guideline on the prevention and control of healthcare associated infection in primary and community care http://guidance.nice.org.uk/PH36
86	SH	**Royal College of Paediatrics and Child Health**	12	4.3.2	A number of BPRS/BTS respondents felt that the use of montelukast should be covered in the treatment section particularly given the conflicting nature of the published data.	Thank you for your comment. As Montelukast is increasingly being used in UK practice it will be added to the list of treatments covered by the guideline.
87	SH	**Twins and**	1	4.3.2	It is disappointing that the Prevention of bronchiolitis by the use	Thank you for your comment.

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		Multiple Births Association			of palivizumab for immunoprophylaxis of RSV is not being reviewed. The JCVI guidance is shortly to be superseded by policy from the nhs commissioning board. Nevertheless, this form of guidance/policy would benefit greatly from being subject to the scrutiny provided by the NICE process.	Guidance on the use of palivizumab comes under the remit of the JCVI, so it cannot included in this guideline.
88	SH	**Twins and Multiple Births Association**	2		It would have been helpful to the consideration of the issue for the latest data on the economic benefits of immunisation to have been reviewed against the financial and social costs of babies developing Bronchiolitis	Thank you for your comment. Immunisation to prevent bronchiolitis comes under the remit of the JCVI, and so cannot be covered by this guideline.
89	SH	**Twins and Multiple Births Association**	3		In the call for further research, it will be vital to identify the need for further research into the potential link between Bronchiolitis and developing ashma.	Thank you for your comment. Recommendations for future research will be based on gaps in the evidence base identified during the reviewing process. This may include the link between bronchiolitis and asthma.

These organisations were approached but did not respond:

Allocate Software PLC
Association of Anaesthetists of Great Britain and Ireland
Association of Paediatric Chartered Physiotherapists
Association of Paediatric Emergency Medicine
Barnsley Hospital NHS Foundation Trust
Birmingham Children's Hospital NHS Foundation Trust
Bliss
Breastfeeding Network
British Geriatrics Society

British Infection Association
British Lung Foundation
British Medical Association
British Medical Journal
British National Formulary
British Nuclear Cardiology Society
British Psychological Society
British Society for Allergy & Clinical Immunology
British Society of Paediatric Radiology
Calderdale and Huddersfield NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Capsulation PPS
Care Quality Commission (CQC)
Clarity Informatics Ltd
Countess of Chester Hospital NHS Foundation Trust
Covidien Ltd.
Croydon Health Services NHS Trust
Department of Health, Social Services and Public Safety - Northern Ireland
East and North Hertfordshire NHS Trust
Five Boroughs Partnership NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Hockley Medical Practice
Imperial College Healthcare NHS Trust
Institute of Biomedical Science
Luton and Dunstable Hospital NHS Trust
Medicines and Healthcare products Regulatory Agency
Ministry of Defence
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health

National Collaborating Centre for Women's and Children's Health
National Institute for Health Research Health Technology Assessment Programme
National Patient Safety Agency
National Treatment Agency for Substance Misuse
NHS Commissioning Board
NHS Connecting for Health
NHS County Durham and Darlington
NHS Plus
NHS Richmond
NICE technical lead
NICE TLOC GDG
North West London Perinatal Network
Northern Ireland Chest Heart and Stroke
Nottingham City Council
Parenteral and Enteral Nutrition Group
Pharmaxis Pharmaceuticals Ltd
Primary Care Respiratory Society UK
Public Health Wales NHS Trust
Public Health Wales NHS Trust
Royal Brompton Hospital & Harefield NHS Trust
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Royal Pharmaceutical Society
Scottish Intercollegiate Guidelines Network
Sheffield Teaching Hospitals NHS Foundation Trust
Social Care Institute for Excellence

South London & Maudsley NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Southport and Ormskirk Hospital NHS Trust
St John Ambulance
St Mary's Hospital
Walsall Local Involvement Network
Welsh Government
Welsh Scientific Advisory Committee
Western Sussex Hospitals NHS Trust
Wirral University Teaching Hospital NHS Foundation Trust
York Hospitals NHS Foundation Trust