responsible, *M. catarrhalis*, *S. pneumoniae*, and *H. influenzae* have also been implicated.

Many of the manifestations of bacterial tracheitis are similar to those of LTB but are unresponsive to LTB therapy. The child has a history of previous URI with croupy cough, stridor unaffected by position, toxicity, absence of drooling, and high fever. Thick, purulent tracheal secretions are common, and respiratory difficulties are secondary to these copious secretions. The child's white cell count will be elevated.

Therapeutic Management and Nursing Care Management

Bacterial tracheitis requires vigorous management with oxygen therapy, antipyretics, and antibiotics. Early recognition to prevent life-threatening airway obstruction is essential. Many children with bacterial tracheitis need endotracheal intubation and mechanical ventilation for airway obstruction.

Infections of the Lower Airways

The reactive portion of the lower respiratory tract includes the bronchi and bronchioles in children. The smooth muscle in these structures represents a major factor in the constriction of the airway, particularly in the bronchioles, the portion that extends from the bronchi to the alveoli. Table 21-2 compares some of the major features of bronchial and bronchiolar infections.

TABLE 21-2

Comparison of Conditions Affecting the Bronchi

	Asthma*	Bronchitis	Bronchiolitis
Description	Exaggerated response of bronchi to a trigger such as URI, animal dander, cold air, exercise Bronchospasm, exudation, and edema of bronchi Inflammatory response	Usually occurs in association with URI Seldom an isolated entity	Most common infectious disease of lower airways. Maximum obstructive impact at bronchiolar level
Age group affected	Infancy to adolescence	First 4 years of life	Usually children 2 to 12 months old; rare after 2 years old Peak incidence,