abdomen in young children. Chills and meningeal symptoms (**meningism**) without meningitis are common.

Most older children with pneumonia can be treated at home if the condition is recognized and treatment is initiated early. Antibiotic therapy, rest, liberal oral intake of fluid, and administration of an antipyretic for fever are the principal therapeutic measures. Chest percussion and postural drainage may be indicated, but there is a lack of evidence to show that they have benefit to children with pneumonia.

A follow-up examination is recommended for small infants and toddlers. Hospitalization is indicated when pleural effusion or empyema accompanies the disease, when moderate or severe respiratory distress or deoxygenation occurs, in situations in which compliance with therapy is estimated to be poor, in infants younger than 6 months old, and when there are chronic illnesses such as congenital heart disease or BPD (Barson, 2015). IV fluids may be necessary to ensure adequate hydration, and oxygen is required if the child is in respiratory distress; some children may require initial therapy with parenteral antibiotics because of the severity of illness.

Complications

At present, the classic features and clinical course of pneumonia are seen infrequently because of early and vigorous antibiotic and supportive therapy. However, some children, especially infants, with staphylococcal pneumonia develop empyema, pyopneumothorax, or tension pneumothorax. AOM and pleural effusion are common in children with pneumococcal pneumonia (Box 21-10) (see Translating Evidence into Practice box). As previously mentioned, vaccination with pneumococcal vaccines is an important part of preventing pneumococcal pneumonia.

Translating Evidence into Practice

Nursing Interventions for Prevention of Ventilator-Associated Pneumonia in Children

Ask the Question

PICOT Question