deep suctioning in the first day of admission and not suctioning the nose at least every 4 hours results in a longer length of stay for infants (Mussman, Parker, Statile, et al, 2013).

Fluids by mouth may be contraindicated because of tachypnea, weakness, and fatigue; therefore, IV fluids may be used until the acute stage of the disease has passed. Nasogastric (NG) fluids may be required if the infant is unable to tolerate oral fluids and a peripheral IV is difficult to establish.

Clinical assessments, noninvasive oxygen monitoring, and in severe cases, blood gas values may guide therapy. Medical therapy for bronchiolitis is primarily supportive and aimed at decreasing airway hyperresonance and inflammation and promoting adequate fluid intake. Racemic epinephrine has been shown to produce modest improvement in ventilation status. The use of systemic corticosteroids is controversial but may be used in some centers. A recent Cochrane Review found no evidence to support the use of antibiotics for bronchiolitis; therefore, antibiotics should not be part of the treatment of bronchiolitis unless there is a coexisting bacterial infection, such as OM or pneumonia (Farley, Spurling, Eriksson, et al, 2014). Additional recommendations from the American Academy of Pediatrics clinical practice guideline are to encourage breastfeeding, avoid passive tobacco smoke exposure, and promote preventive measures, including hand washing and the administration of palivizumab (Synagis) to high-risk infants (Ralston, Lieberthal, Meissner, et al, 2014). The American Academy of Pediatrics no longer recommends a trial dose of a bronchodilator to be used for patient with bronchiolitis (Ralston, Lieberthal, Meissner, et al, 2014). They also specify that testing for specific viruses is unnecessary because bronchiolitis may be caused by multiple viruses although some institutions continue to test to detect RSV.

Ribavirin, an antiviral agent (synthetic nucleoside analog), is the only specific therapy approved for hospitalized children. Due to potential toxic effects of the medication to exposed health care staff and conflicting results of efficacy, the American Academy of Pediatrics recommends against routine use of ribavirin to treat RSV. Based on current literature, ribavirin should be reserved for treatment in patients at high risk for mortality related to the infection, such as infants and transplant recipients (Turner, Kopp,