IMPACT FACTOR (UIF): 8.59
IMPACT FACTOR (SJIF): 8.59

ISSN: 2277-2952

TJM

Thematics Journal of Microbiology

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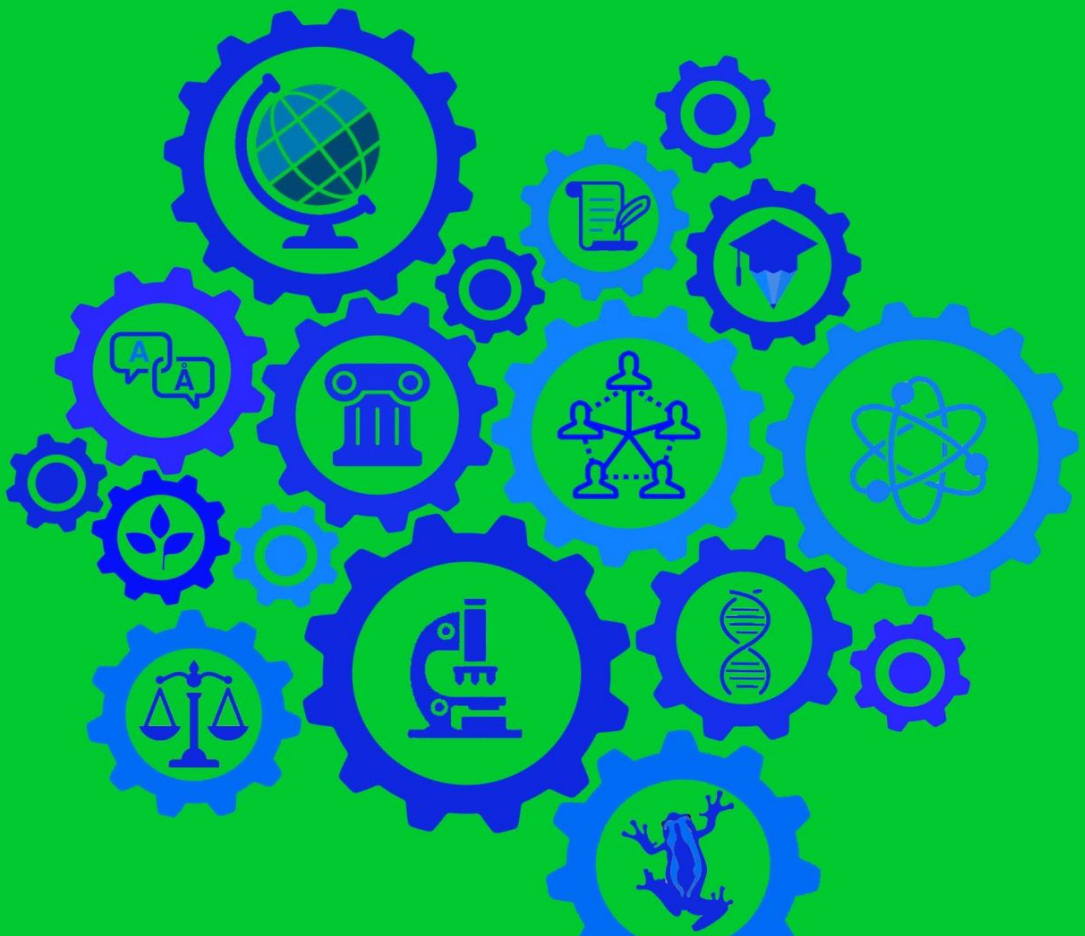

TJM - Tematics journal of Microbiology
ISSN 2277-2952
Vol-8-Issue-1-2024
http://thematicsjournals.in
Impact factor 2024

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TJM - Tematics journal of Microbiology
ISSN 2277-2952
Vol-8-Issue-1-2024
http://thematicsjournals.in
Impact factor 2024

Acute Bronchiolitis and Predictors of Severe Forms in Children Under 2 Years Old

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Acute bronchiolitis should be differentiated from diseases such as pneumonia, including aspiration pneumonia, obstructive bronchitis, chronic bronchial and/or lung diseases, and bronchial asthma [16]. In young children with febrile fever, a bacteriological examination of the urine is recommended to rule out urinary tract infections (UTIs) [11–13]. The main goal of treating acute bronchiolitis (AB) is to normalize external respiratory function, ensure adequate hydration, and maintain oxygenation. Therapy is primarily supportive in most cases and aims to minimize the use of excessive medications and procedures [17–18]. To reduce hypoxemia, inhalations of warm, humidified oxygen are prescribed. Nasal congestion is a common problem and significantly increases respiratory failure (RF); thus, nasal cavity sanitation is a necessary procedure for bronchiolitis. Infants under one year of age with hypoxemia and progressive RF require non-invasive positive pressure support (NCPAP) [19]. The main drug groups used for AB include inhaled bronchodilators and glucocorticosteroids [20]. Antibiotics are not indicated for acute bronchiolitis unless there is a concurrent bacterial infection. The effectiveness and safety of managing children with AB without antibacterial agents have been demonstrated in modern studies [21]. The decision to hospitalize a child with bronchiolitis is usually based on the patient's age, stage of the disease, presence of risk factors, severity of respiratory distress, and ability to take fluids [22]. The prognosis after acute bronchiolitis is usually favorable; post-infectious obliterative bronchiolitis with subsequent disability is rarely observed. 50% of children who have had AB may later experience episodes of bronchial obstruction [23].