

Clinical Guideline

Pneumonia (3 months – 18 years)

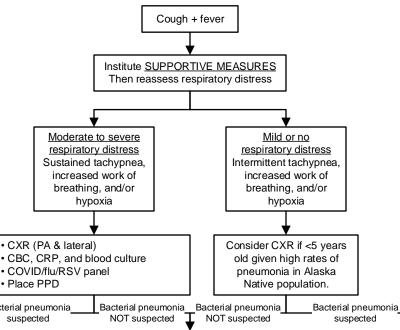
- If patient is <90 days and febrile, please see fever guidelines.
- Pneumonia is a clinical diagnosis and does not require Xray findings.

Hypoxia

<90% while awake <88% while asleep Sustained for >10 minutes

Pulse-Oximetry Monitoring

- Pulse-ox may be ordered Q4h (not continuously) if age >6 months and patient is stable.
- · Being on oxygen does not mandate continuous pulseoximetry if patient is stable.



Consider other

diagnoses: viral pneumonia, RAD, bronchiolitis, TB,

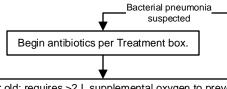
acidosis, toxins, etc.

SUPPORTIVE MEASURES

- · Control fever, as it can be an independent cause of respiratory distress and tachycardia.
- Nasal suction with nasal bulb syringe and olive tip plus saline.
- · Hydration by IV or enteral (including NG and G-tube).
- Gentle P&PD/CPT if helpful.
- · Saline neb (either 0.9% or hypertonic 3%).
- Consider albuterol trial. especially in Alaska Native patients as they have high rates of

Village Management

Any child <5 years with suspected pneumonia should be evaluated in Bethel or an SRC.



- If <1 year old: requires >2 L supplemental oxygen to prevent hypoxia or improve WOB?
- If ≥1 year old: requires >3 L supplemental oxygen to prevent hypoxia or improve WOB?
- Requires neb treatments more frequently than Q2-3h for >8
- · Sustained tachycardia, tachypnea, or respiratory distress despite treatment?

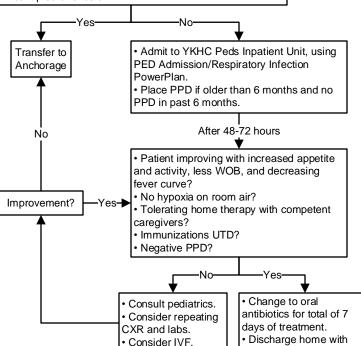
NOTE: There is limited evidence to support the use

of procalcitonin to guide antimicrobial treatment in

pediatric pneumonia, so it should not be used to

guide management decisions at this time.

Significant pleural effusion?



follow-up within 48-72

No routine follow-up

CXR unless recurrent

infiltrate in same lobe; in

that case, repeat CXR in

hours.

4-6 weeks.

• Place PPD if older than 6 months and no PPD in past 6 months.

Prescribe antibiotics for 7 days per Treatment box.

• Discharge home with follow-up within 48-72 hours.

 No routine follow-up CXR unless recurrent infiltrate in same lobe; in that case, repeat CXR in 4-6 weeks.

Treatment

NOTE: If known viral infection, viral pneumonia is likely; antibiotics not indicated. If influenza positive, see Influenza quideline for oseltamivir criteria.

Outpatient

1st line: amoxicillin 45 mg/kg/dose PO BID x7 days 2nd line: Augmentin 45 mg/kg/dose PO BID x7 days 3rd line: cefdinir 7 mg/kg/dose PO BID x7 days

Inpatient

1st line: ampicillin 50 mg/kg/dose IV Q6h 2nd line: Unasyn 50 mg/kg/dose IV Q6h 3rd line: ceftriaxone 75 mg/kg/dose IV Q24h

If not fully immunized, suspicion for H influenzae, or complicated pneumonia (pleural effusion, multilobar involvement, concern for bacteremia, etc.): Start with ceftriaxone. When improving, complete 10 day course with narrower spectrum oral antibiotic, as appropriate.

For H influenzae type A: At least one dose of ceftriaxone or four days of rifampin is necessary for decolonization. Remainder of course may be completed with a penicillin, if sensitive.

For PCN allergy: If reaction was non-anaphylactic, may trial amoxicillin with monitoring. If reaction was anaphylaxis, treat with a cephalosporin. If any questions, please obtain a pediatrics consult.

Azithromycin: Do not prescribe azithromycin unless there is evidence of an atypical pathogen and child is >5 years. Must be prescribed in addition to primary treatment above.

RUL infiltrate: consider starting with Augmentin/Unasyn to cover for oral anaerobes. Consider thickener.

For Chronic Cough: See Bronchiectasis/Chronic Cough guideline.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 12/7/21.

Click here to see the supplemental resources for this guideline.

f comments about this guideline, please contact Jennifer_Hampton@ykhc.org