RECURRENT PNEUMONIA REFERRAL GUIDELINE

MAINE MEDICAL PARTNERS - PEDIATRIC SPECIALTY CARE (DIV. PULMONARY MEDICINE) • 887 CONGRESS ST, SUITE 320, PORTLAND, ME • (207) 662-5522

HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

HISTORY:
Close relative with cystic fibrosis or primary ciliary dyskinesia

Symptoms associated with feeding

SYMPTOMS AND EXAM:
ICU admission for pneumonia

2 or more hospitalizations for pneumonia

Failure to thrive

Digital clubbing

Chest deformity

Crackles for more than 8 weeks

Fixed monophonic wheezing

LABS/IMAGING:
Persistent change on chest x-ray

SUGGESTED PREVISIT WORKUP

RECOMMEND:
Consult pulmonary medicine

Urgent consults are to expedite assessment of underlying anatomic or medical conditions that could be compromise airway patency

The intention is to prevent a life threatening complication and initiate therapies to reduce morbidity

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

HISTORY:
History of bronchopulmonary dysplasia

Family history of genetic disorder involving the respiratory tract

Unexplained death of a family member from a respiratory infection

SYMPTOMS AND EXAM:
2 or more pneumonias diagnosed in a year

3 life time pneumonias

ICU care for a pneumonia

Short periods of wellness

Involvement of an additional organ system (skin abscess, FTT, etc.)

No response to asthma therapy

LABS/IMAGING:
Complex pneumonia on CXR

Unusual organisms on culture

SUGGESTED WORKUP

RECOMMEND:
Trial asthma therapy and/or escalate asthma therapy

Swallow study for children who gag and choke on food or drink

Environmental controls detailed in “green zone”

Pulmonary referral suggested

Consider GI referral if indicated by symptoms or studies

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

HISTORY:
No family history of genetic disorders involving the respiratory tract (primary ciliary dyskinesia or cystic fibrosis, etc.)

SYMPTOMS AND EXAM:
Self-limiting infections

Long periods of wellness

Normal growth and physical exam

Quick response to therapy with complete recovery

No other organ systems involved

LABS/IMAGING:
Normal chest x-ray

No unusual pathogens isolated by culture

SUGGESTED MANAGEMENT

MONITOR FOR:
Symptoms of dysphagia

Symptoms of reflux

Response to asthma therapy

RECOMMEND:
Limiting tobacco smoke exposure

Limiting exposure to animals in the sleeping area and living environment

No sleeping with a bottle

Limiting exposure to large daycare settings

CLINICAL PEARLS

- A bacterial pneumonia is VERY unlikely if the patient does not have a fever.
- Absence of tachypnea can help rule out pneumonia in a child without neuromuscular weakness.
- A chest x-ray can’t distinguish the etiology of a pneumonia (viral vs bacterial) and does not improve outcomes or change treatment in children with community acquired pneumonia.
- Undertreated asthma is the most common diagnosis made in children referred for recurrent pneumonia.

Recurrent pneumonia in children: a reasoned diagnostic approach and a single centre experience Int J. Mol. Sci 2017, 18, 296

Community-acquired pneumonia in children. Am Fam Physician. 2012 Oct 1;86(7):661-667

Maine Medical PARTNERS

10/17