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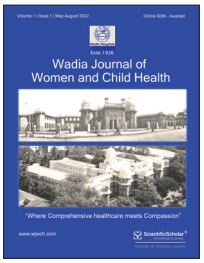

Brief Communication

Respiratory infections in children - current trends

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Although COVID-19 infections are on the decline, respiratory infections in children due to other pathogens have suddenly increased over the last few months. We wish to highlight the rational approach to clinical observations and principles of management of these seasonal respiratory illnesses. As viral infections are more common, indiscriminate use of antibiotics should be stopped. It is clinically very difficult to distinguish a viral etiology as the presenting symptoms are the same – fever, cold, cough, sore throat, and respiratory distress in some.

Nasopharyngeal polymerase chain reaction is being increasingly used to aid the diagnosis but only detection of *Adenovirus*, *Respiratory syncytial virus* or *Influenza virus* carries significance. Empiric treatment with Oseltamivir should be considered only in outbreaks with lower respiratory tract infection with low to normal leucocyte counts, normal or mildly elevated C-reactive protein, and diffuse non-lobar infiltrates seen on chest X-ray. Adenoviral infections typically present with high-grade fever, tonsillar enlargement in older children, and bronchiolitis or lower respiratory infection in young infants. Fever with tachypnea and wheezing is a common presentation in children. These children are usually not so sick. Although hospital admissions are largely due to wheeze-associated lower respiratory infections (WALRI) during the later half of the year (June–November); this year, the duration has been prolonged. As these children with WALRI have viral infections, they need only bronchodilator therapy with or without supplemental oxygen. A history of atopy suggests an asthmatic progression and may warrant a trial of inhaled corticosteroids therapy more so when they present with repeated episodes. Although montelukast, a leukotriene receptor antagonist, has been used to help decrease airway inflammation and cause relaxation of smooth muscles, this drug has not been found useful in these cases. Cold and cough medications including cough suppressants and mucolytics are avoided in children below 4 years of age. Steroids and antibiotics have a limited role in managing viral respiratory infections in general.

A sick looking child with fever, cough, and respiratory distress with crepitations is more likely to have a bacterial pneumonia and the drug of choice would be amoxicillin or amoxicillin-clavulanate and cephalosporins are avoided. Raised neutrophils counts and C-reactive protein suggest a bacterial etiology although not diagnostic. Azithromycin should be reserved for community acquired pneumonia in children above 5 years of age, wherein cough is the predominant symptom and chest X-ray is essentially normal. Staphylococcal infections are usually suspected in pneumonia in the sick young child with pneumatoceles, necrosis, or empyema. Cloxacillin is required in addition to ceftriaxone and a suspicion of panton-valentine leucocidin toxin requires clindamycin or linezolid. We recommend rational use of antibiotics, antivirals, and

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inhaled medication for treatment of respiratory infections in children based on symptoms and severity.

Declaration of patient consent

Patient's consent not required as there are no patients involved in this study.

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Conflicts of interest

There are no conflicts of interest.