ASTHMA

Clinical considerations for CXR

in children 2yr—17yr with known/suspected asthma.

If **NONE** of these are present, question your reason for a CXR.

- □ Fever ≥38°C (100°F) for ≥72 hrs
- □ Toxic, ill appearance, somnolent, lethargic, or listless
- □ Focal lung exam findings (decreased breath sounds, rales, rhonchi) or crepitus
- □ Suspected foreign body ingestion or choking episode in past 2 wks
- □ Chest pain
- □ **Worsening** accessory muscle use, nasal flaring, head bobbing, severe retractions after standard asthma treatment in ED including:
  - □ 3 treatments with inhaled beta agonist + steroids
- □ Requiring escalation of care:
  - □ Continuous albuterol, magnesium, epinephrine, terbutaline

Comorbidities

- □ Cerebral palsy &/or neuromuscular disease
- □ Prematurity (<37 wks gestation)
- □ Bronchopulmonary dysplasia
- □ Tracheostomy
- □ Cystic fibrosis
- □ Ciliary dyskinesias
- □ Congenital heart disease
- □ Sickle cell disease
- □ Immunosuppression
  - □ Cancer
  - □ HIV/AIDS
  - □ Transplant

*Presence of one or more of these does **NOT** automatically require a CXR.*

**If wheezing is occurring without a clear atopic etiology or URI symptoms, diagnostic imaging may be considered on a case-by-case basis.*

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BRONCHIOLITIS

Clinical considerations for CXR

in children 2mo—2yr with history & exam

consistent with bronchiolitis.

If **NONE** of these are present, question your reason for a CXR.

- ☐ Fever ≥38°C (100°F) for ≥72 hrs
- ☐ Toxic, ill appearance, somnolent, lethargic, or listless
- ☐ Focal lung exam findings (decreased breath sounds, rales, rhonchi) or crepitus
- ☐ Suspected foreign body ingestion or choking episode in past 2 wks
- ☐ Chest pain
- ☐ **Worsening** accessory muscle use, nasal flaring, head bobbing, severe retractions
- ☐ Requiring escalation of care:
  - ☐ High flow oxygen
  - ☐ CPAP, BiPAP

Comorbidities

- ☐ Cerebral palsy &/or neuromuscular disease
- ☐ Prematurity (<37 wks gestation)
- ☐ Bronchopulmonary dysplasia
- ☐ Tracheostomy
- ☐ Cystic fibrosis
- ☐ Ciliary dyskinesias
- ☐ Congenital heart disease
- ☐ Sickle cell disease
- ☐ Immunosuppression
  - ☐ Cancer
  - ☐ HIV/AIDS
  - ☐ Transplant

*Presence of one or more of these does **NOT** automatically require a CXR.*

**If wheezing is occurring without a clear atopic etiology or URI symptoms, diagnostic imaging may be considered on a case-by-case basis.*

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CROUP

Clinical considerations for CXR

in children 6mo—3yr with history & exam consistent with croup.

If **NONE** of these are present, question your reason for a CXR.

- ☐ Fever ≥38°C (100°F) for ≥72 hrs
- ☐ Toxic, ill appearance, somnolent, lethargic, or listless
- ☐ Focal lung exam findings (decreased breath sounds, rales, rhonchi) or crepitus
- ☐ Suspected foreign body ingestion or choking episode in past 2 wks
- ☐ Chest pain
- ☐ **Worsening** stridor, accessory muscle use, nasal flaring, head bobbing, severe retractions after standard croup treatment in ED including:
  - ☐ Steroids
  - ☐ Racemic epinephrine
- ☐ Requiring escalation of care:
  - ☐ ≥2 doses of racemic epinephrine

Comorbidities

- ☐ Cerebral palsy &/or neuromuscular disease
- ☐ Prematurity (<37 wks gestation)
- ☐ Bronchopulmonary dysplasia
- ☐ Tracheostomy
- ☐ Cystic fibrosis
- ☐ Ciliary dyskinesias
- ☐ Congenital heart disease
- ☐ Sickle cell disease
- ☐ Immunosuppression
  - ☐ Cancer
  - ☐ HIV/AIDS
  - ☐ Transplant

*Presence of one or more of these does **NOT** automatically require a CXR.*

**If wheezing is occurring without a clear atopic etiology or URI symptoms, diagnostic imaging may be considered on a case-by-case basis.*

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