

DEFINITION

- A cough is the sound made when the cough reflex suddenly forces air and secretions from the lungs.
- A coughing spell or fit is over 5 minutes of continuous coughing. Paroxysmal coughing is even more prolonged and intense.
- The cough reflex protects the airways from infection.
- Caution: Must rule-out respiratory distress in this guideline
- COVID-19 infections can present with these respiratory symptoms. During high community spread, use the COVID guideline for these clinical presentations. It will adequately cover triage and care advice. If you need more detailed information, use 2 guidelines.

Respiratory Distress Severity is defined:

- **MILD:** no SOB at rest, mild SOB with walking, speaks normally in sentences, can lay down flat, no retractions.
- **MODERATE:** SOB at rest, speaks in phrases, prefers to sit (can't lay down flat), mild retractions.
- **SEVERE:** severe SOB at rest, speaks in single words, struggling to breathe, severe retractions. (Exception: these symptoms are transient and only present when coughing)

INITIAL ASSESSMENT QUESTIONS

Note to Triager - Respiratory Distress: Always rule out respiratory distress (also known as working hard to breathe or shortness of breath). Listen for grunting, stridor, wheezing, tachypnea in these calls. How to assess: Listen to the child's breathing early in your assessment. Reason: What you hear is often more valid than the caller's answers to your triage questions.

1. ONSET: "When did the cough start?"
2. SEVERITY: "How bad is the cough today?"
3. COUGHING SPELLS: "Does he go into coughing spells where he can't stop?" If so, ask: "How long do they last?"
4. CROUP: "Is it a barking, croupy cough?"
5. RESPIRATORY STATUS: "Describe your child's breathing when he's not coughing. What does it sound like?" (eg wheezing, stridor, grunting, weak cry, unable to speak, retractions, rapid rate, cyanosis)
6. CHILD'S APPEARANCE: "How sick is your child acting?" "What is he doing right now?" If asleep, ask: "How was he acting before he went to sleep?"
7. FEVER: "Does your child have a fever?" If so, ask: "What is it, how was it measured, and when did it start?"
8. CAUSE: "What do you think is causing the cough?" Age 6 months to 4 years, ask: "Could he have choked on something?"

- Author's note: IAQ's are intended for training purposes and not meant to be required on every call.

TRIAGE ASSESSMENT QUESTIONS

Call EMS 911 Now

[1] Difficulty breathing AND [2] SEVERE (struggling for each breath, unable to speak or cry, grunting sounds, severe retractions) AND [3] present when not coughing (Triage tip: Listen to the child's breathing.)

CA: 50, 9

Slow, shallow, weak breathing

R/O: respiratory depression with impending apnea

CA: 50, 9

Passed out or stopped breathing

R/O: apnea, anaphylaxis, cough syncope

CA: 50, 9

[1] Bluish (or gray) lips or face now AND [2] persists when not coughing

R/O: cyanosis and need for oxygen

CA: 50, 9

Very weak (doesn't move or make eye contact)

R/O: sepsis or shock

CA: 50, 9

Sounds like a life-threatening emergency to the triager

CA: 50, 9

See More Appropriate Guideline

Stridor (harsh sound with breathing in) is present when listening to child

Go to Guideline: Croup (Pediatric)

Constant hoarse voice AND deep barking cough

Go to Guideline: Croup (Pediatric)

Choked on a small object or food that could be caught in the throat

Go to Guideline: Choking - Inhaled Foreign Body (Pediatric)

Previous diagnosis of asthma (or RAD) OR regular use of asthma medicines for wheezing

Go to Guideline: Asthma (Pediatric)

Bronchiolitis or RSV has been diagnosed within the last 2 weeks

Go to Guideline: Bronchiolitis Follow-Up Call (Pediatric)

[1] Age < 2 years AND [2] given albuterol inhaler or neb for home treatment within the last 2 weeks

Go to Guideline: Bronchiolitis Follow-Up Call (Pediatric)

[1] Age > 2 years AND [2] given albuterol inhaler or neb for home treatment within the last 2 weeks

Go to Guideline: Asthma (Pediatric)

Wheezing is present, but NO previous diagnosis of asthma (RAD) or regular use of asthma medicines for wheezing

Go to Guideline: Wheezing - Other Than Asthma (Pediatric)

COVID-19 suspected by triager (such as known COVID-19 in household)

Go to Guideline: COVID-19 - Diagnosed or Suspected (Pediatric)

[1] Coughing occurs AND [2] within 21 days of whooping cough EXPOSURE

Go to Guideline: Whooping Cough Exposure (Pediatric)

Whooping cough (pertussis) has been diagnosed

Go to Guideline: Whooping Cough Follow-up Call

Go to ED Now

[1] Coughed up blood AND [2] large amount

CA: 51, 9

Retractions - skin between the ribs is pulling in (sinking in) with each breath

R/O: pneumonia

CA: 51, 9

Stridor (harsh sound with breathing in) is present

R/O: croup

CA: 51, 9

[1] Lips or face have turned bluish BUT [2] only during coughing fits

R/O: bronchiolitis, FB or pertussis

CA: 51, 9

[1] Age < 12 weeks AND [2] fever 100.4 F (38.0 C) or higher rectally

R/O: sepsis

CA: 51, 16, 9

Go to ED Now (or PCP triage)

[1] Oxygen level <92% (<90% if altitude > 5000 feet) AND [2] any trouble breathing

CA: 52, 9

[1] Difficulty breathing AND [2] not severe AND [3] still present when not coughing (Triage tip: Listen to the child's breathing.)

CA: 52, 9

[1] Age < 3 years AND [2] continuous coughing AND [3] sudden onset today AND [4] no fever or symptoms of a cold

R/O: airway FB

CA: 52, 9

Breathing fast (Breaths/min > 60 if < 2 mo; > 50 if 2-12 mo; > 40 if 1-5 years; > 30 if 6-11 years; > 20 if > 12 years old)

R/O: respiratory distress. (Caution: Do not attribute abnormal RR to fever)

CA: 52, 9

[1] Age < 6 months AND [2] wheezing is present BUT [3] no trouble breathing

CA: 52, 9

[1] SEVERE chest pain (excruciating) AND [2] present now

R/O: pneumonia, pleurisy

CA: 52, 9

[1] Drooling or spitting out saliva AND [2] can't swallow fluids

R/O: peritonsillar abscess, retropharyngeal abscess

CA: 52, 9

[1] Dehydration suspected AND [2] age < 1 year AND [3] no urine > 8 hours PLUS very dry mouth, no tears, or ill-appearing, etc.)

CA: 52, 9

[1] Dehydration suspected AND [2] age > 1 year AND [3] no urine > 12 hours PLUS very dry mouth, no tears, or ill-appearing, etc.)

CA: 52, 9

[1] Shaking chills (severe shivering) NOW (won't stop) AND [2] present constantly > 30 minutes

R/O: pneumonia, sepsis

CA: 52, 19, 9

[1] Fever AND [2] > 105 F (40.6 C) NOW or RECURRENT by any route OR axillary > 104 F (40 C)

R/O: serious bacterial infection

CA: 52, 18, 9

[1] Fever AND [2] weak immune system (sickle cell disease, HIV, chemotherapy, organ transplant, adrenal insufficiency, chronic oral steroids, etc)

R/O: serious bacterial infection. Note: if available, refer to established specialist.

CA: 52, 9

Child sounds very sick or weak to the triager

Reason: severe acute illness or serious complication suspected

CA: 52, 9

See HCP (or PCP Triage) Within 4 Hours

[1] Age < 1 month old AND [2] lots of coughing

R/O: pneumonia

CA: 53, 17, 9

[1] MODERATE chest pain (by caller's report) AND [2] can't take a deep breath

R/O: pneumonia, pleurisy

CA: 53, 17, 9

[1] Age < 1 year AND [2] continuous (cannot stop) coughing keeps from BOTH feeding and sleeping AND [3] no improvement using cough treatment per guideline

R/O: respiratory distress

CA: 53, 2, 4, 5, 6, 17, 9

Call PCP Now

[1] Oxygen level <92% (90% if altitude > 5000 feet) AND [2] no trouble breathing

Note to triager: abnormal reading needs to persist or occur more than once

CA: 59, 9

High-risk child (e.g., underlying lung, heart or severe neuromuscular disease)

Reason: high risk for respiratory distress

CA: 59, 36, 2, 3, 4, 23, 19, 37, 9

See PCP Within 24 Hours

Age < 3 months old (Exception: coughs a few times)

R/O: pneumonia, Chlamydia, pertussis

CA: 54, 29, 30, 5, 6, 23, 28, 9

[1] Age 6 months or older AND [2] wheezing is present BUT [3] no trouble breathing

CA: 54, 2, 29, 23, 30, 5, 6, 19, 17, 9

[1] Blood-tinged sputum has been coughed up AND [2] more than once

R/O: pneumonia, foreign body, TB

CA: 54, 2, 3, 4, 5, 6, 23, 17, 9

[1] Age > 1 year AND [2] continuous (cannot stop) coughing keeps from BOTH normal activities and sleeping AND [3] no improvement using cough treatment per guideline

R/O: pertussis, asthma

CA: 54, 2, 3, 4, 20, 5, 6, 23, 17, 9

Earache is also present

R/O: ear infection

CA: 54, 1, 2, 3, 4, 5, 6, 21, 22, 23, 17, 9

[1] Age < 2 years AND [2] ear infection suspected by triager

Reason: recognizes child too young to report earache

CA: 54, 1, 2, 3, 4, 5, 6, 21, 22, 23, 17, 9

[1] Age > 5 years AND [2] sinus pain (not just congestion) is also present

R/O: cough triggered by sinusitis

CA: 54, 1, 2, 3, 4, 5, 6, 24, 25, 21, 23, 17, 9

Fever present > 3 days (72 hours)

R/O: pneumonia

CA: 54, 2, 3, 4, 5, 6, 19, 23, 17, 9

See PCP Within 3 Days

[1] Age 3 to 6 months old AND [2] fever with the cough

R/O: pneumonia

CA: 55, 2, 29, 23, 30, 5, 6, 19, 35, 9

[1] Fever returns after gone for over 24 hours AND [2] symptoms worse

R/O: otitis media, sinusitis, new URI

CA: 55, 2, 3, 4, 5, 6, 19, 23, 40, 17, 9

[1] New fever develops after having cough for 3 or more days (over 72 hours) AND [2] symptoms worse

R/O: otitis media, sinusitis, new URI

CA: 55, 2, 3, 4, 5, 6, 19, 23, 40, 17, 9

[1] Coughing has caused chest pain AND [2] present even when not coughing

R/O: pleurisy

CA: 55, 27, 2, 3, 4, 5, 6, 23, 17, 9

[1] Pollen-related cough (allergic cough) AND [2] not relieved by antihistamines

R/O: asthma

CA: 55, 32, 26, 33, 6, 40, 17, 9

Cough only occurs with exercise

R/O: exercise-induced bronchospasm

CA: 55, 1, 2, 3, 4, 6, 23, 17, 9

[1] Vomiting from hard coughing AND [2] 3 or more times

CA: 55, 15, 10, 2, 3, 4, 5, 6, 40, 17, 9

[1] Coughing has kept home from school AND [2] absent 3 or more days

CA: 55, 2, 3, 4, 5, 6, 23, 17, 9

[1] Nasal discharge AND [2] present > 14 days

R/O: *strep rhinitis in infants, sinusitis, allergic rhinitis*

CA: 55, 11, 13, 12, 2, 3, 4, 5, 6, 17, 9

[1] Whooping cough in the community AND [2] coughing lasts > 2 weeks

CA: 55, 1, 2, 3, 4, 5, 6, 31, 23, 17, 9

Cough has been present for > 3 weeks

R/O: *asthma, foreign body, pertussis, smoking teens*

CA: 55, 1, 2, 3, 4, 5, 6, 23, 17, 9

Vaping or smoking concerns

Reason: *discuss health risks with HCP*

CA: 55, 39, 2, 3, 4, 6, 7, 37, 9

Home Care

Pollen-related cough (allergic cough)

CA: 58, 32, 26, 33, 6, 34, 9

Cough with no complications

CA: 58, 1, 2, 3, 4, 10, 40, 5, 6, 19, 23, 7, 38, 8, 9

ALSO, mild cold symptoms are present

CA: 58, 11, 13, 12, 14, 9

CARE ADVICE (CA) -

- 1. Reassurance and Education:**
 - It doesn't sound like a serious cough.
 - Coughing up mucus is very important for protecting the lungs from pneumonia.
 - We want to encourage a productive cough, not turn it off.
- 2. Homemade Cough Medicine - 6 Months and Older:**
 - **Age 6 months to 1 year:** Give warm clear fluids (e.g., apple juice or lemonade) to thin the mucus and relax the airway. Dosage: 1-2 teaspoons (5-10 ml) four times per day.
 - **Note to Triager:** Option to be discussed only if caller complains that nothing else helps: Give a small amount of corn syrup. Dosage: ¼ teaspoon (1 ml). Can give up to 4 times a day when coughing. Caution: Avoid honey until 1 year old (Reason: risk for botulism).
 - **Age 1 year and older:** Use **Honey** 1/2 to 1 tsp (2 to 5 ml) as needed as a homemade cough medicine. It can thin the secretions and loosen the cough. (If not available, can use corn syrup.)
 - **Age 6 years and older:** Use **Cough Drops** (throat drops) to decrease the tickle in the throat. If not available, can use hard candy. Avoid cough drops before 6 years. Reason: risk of choking.

3. **OTC Cough Medicine - DM:**
 - OTC cough medicines are not recommended. (Reason: no proven benefit for children.)
 - Honey has been shown to work better. (Caution: Avoid honey until 1 year old.)
 - If the caller insists on using one and the child is over 6 years old, use one with dextromethorphan (DM).
 - Follow the instructions on the package.
 - Indication: Give only for severe coughs that interfere with sleep, school or work.
 - Don't use under 6 years of age. Reason: cough is a protective reflex.
4. **Coughing Fits or Spells - Warm Mist and Fluids:**
 - Breathe warm mist (such as with shower running in a closed bathroom).
 - Give warm clear fluids to drink. Examples are apple juice and lemonade.
 - Age less than 6 months: Only give breastmilk or formula.
 - Age 6 - 12 months: Give 1-2 teaspoons (5-10 mL) each time. Limit to 4 times per day.
 - Age 1 year and older: Use 1 ounce (30 mL) or more at a time. Give as much as needed.
 - Reason: Both relax the airway and loosen up any phlegm.
 - What to Expect: The coughing fit should stop. But, your child will still have a cough.
5. **Humidifier:**
 - If the air is dry, use a humidifier in the bedroom (Reason: dry air makes coughs worse).
 - Avoid menthol vapors (Reason: makes coughs worse).
6. **Avoid Tobacco Smoke:**
 - Active or passive smoking makes coughs much worse.
7. **Expected Course:**
 - Viral coughs normally last 2 to 3 weeks.
 - Sometimes the child coughs up lots of phlegm (mucus). The mucus can normally be gray, yellow or green.
 - Antibiotics are not helpful.
8. **Call Back If**
 - Continuous cough persists over 2 hours after cough treatment
 - Signs of respiratory distress
 - Wheezing occurs
 - Fever lasts over 3 days
 - Cough lasts over 3 weeks
 - Your child becomes worse
9. **Care Advice** given per Cough (Pediatric) guideline.
10. **Vomiting with Coughing Fits:**
 - Refeed your child after this type of vomiting.
 - Offer smaller amounts with each feeding to reduce the chances of repeated vomiting (e.g., give less formula per feeding in infants). (Reason: Vomiting more likely with a full stomach.)

11. **Runny Nose - Blow or Suction the Nose:**
 - The nasal mucus and discharge is washing viruses and bacteria out of the nose and sinuses.
 - Having your child blow the nose is all that is needed. Teach your child how to blow the nose at age 2 or 3.
 - For younger children, gently suction the nose with a suction bulb.
 - If the skin around the nostrils becomes sore or irritated, apply a little petroleum jelly twice a day. Cleanse the skin first with water.
12. **Medicines For Colds:**
 - **Cold Medicines:** Don't give any non-prescription cold or cough medicines to young children. They are not approved by the FDA under 6 years. Reasons: not safe and can cause serious side effects. Also, they are not helpful. Reason: They can't remove dried mucus from the nose. Nasal saline works best.
 - **Allergy Medicines:** They are not helpful, unless your child also has nasal allergies. They can also help an allergic cough. Exception for Allergy Medicines: Some parents call for dosage and can't be reassured. If child over age 1, provide correct dosage for allergies (or if PCP has recommended for cold symptoms).
 - **No Antibiotics:** Antibiotics are not helpful for colds. Antibiotics may be used if your child gets an ear or sinus infection.
13. **Nasal Saline to Open a Blocked Nose:**
 - Use saline (salt water) nose drops or spray to loosen up the dried mucus. If you don't have saline, you can use a few drops of bottled water or clean tap water. (If under 1 year old, use bottled water or boiled tap water.)
 - **Step 1:** Put 3 drops in each nostril. Age: If under 1 year old, use 1 drop at a time.
 - **Step 2:** Blow (or suction) each nostril separately, while closing off the other nostril. Then do other side.
 - **Step 3:** Repeat nose drops and blowing (or suctioning) until the discharge is clear.
 - **How Often:** Do nasal saline when your child can't breathe through the nose. Age: If under 1 year old, no more than 4 times per day. Before breast or bottle feedings are a good time.
 - Saline nose drops or spray can be bought in any drugstore. No prescription is needed.
 - Reason for nose drops: Suction or blowing alone can't remove dried or sticky mucus. Also, babies can't nurse or drink from a bottle unless the nose is open.
 - Other option: use a warm shower to loosen mucus. Breathe in the moist air, then blow (or suction) each nostril.
 - For young children, can also use a wet cotton swab to remove sticky mucus.
14. **Call Back If**
 - Fever lasts over 3 days
 - Clear nasal discharge lasts over 14 days
 - Your child becomes worse
15. **Reassurance and Education:**
 - Hard coughing commonly triggers vomiting, especially in young children or those with reflux.
 - Since your child has vomited several times from coughing, he should probably get his cough checked out.
 - If he's breathing normally, however, it's not urgent.
 - Here is some care advice that should help.

16. **Fever Under 3 Months Old - Don't Give Fever Medicine:**
 - Don't give any acetaminophen before being seen.
 - Need accurate documentation of temperature in medical setting to decide if fever is really present. (Reason: may require septic work-up.)
17. **Call Back If:**
 - Trouble breathing occurs
 - Your child becomes worse
18. **Fever Medicine:**
 - To bring down the fever, give acetaminophen every 4 hours **Or** ibuprofen every 6 hours (See Dosage table).
19. **Fever Medicine and Treatment:**
 - For fever above 102 F (39 C), you may use acetaminophen OR ibuprofen (See Dosage table).
 - For fevers 100-102 F (37.8 to 39 C), fever medicines are not needed. Reason: Fever turns on your body's immune system. Fever helps fight the infection.
 - **Exception:** If your child also has definite pain, treat it.
 - **Fluids.** Encourage cool fluids in unlimited amounts. Reason: prevent dehydration. Age younger than 6 months, only give formula or breastmilk.
 - **Clothing.** For all children, dress in 1 layer of clothing, unless shivering. For shivering, use a blanket until it stops.
 - **Caution:** if a baby under 1 year has a fever, do not overdress or bundle up. Reason: Babies can get over-heated more easily than older children.
20. **Honey for Coughing Fits or Spells if Over 1 Year:**
 - If swallowing warm fluids and breathing warm mist doesn't help, give honey. Age limit: Must be over 1 year. Reason: Can soothe the throat. Amount: 1-2 teaspoons (5-10 ml).
 - If child 6 years or older and honey doesn't help, give a single dose of Benadryl. (See Dosage Table). Reason: Benadryl may help the child relax enough to stop the coughing spell.
21. **Pain Medicine:**
 - For pain relief, give acetaminophen every 4 hours **Or** ibuprofen every 6 hours as needed. (See Dosage table.)
22. **Cold or Hot Pack for Ear Pain:**
 - Apply a cold pack or a cold wet washcloth to outer ear for 20 minutes to reduce pain while medicine takes effect.
 - Note: Some children prefer local heat for 20 minutes.
 - Caution: Cold or hot pack applied too long could cause frostbite or burn.
23. **Fluids - Offer More:**
 - Encourage your child to drink adequate fluids to prevent dehydration.
 - This will also thin out the nasal secretions and loosen the phlegm in the lungs.

24. **Nasal Saline to Open a Blocked Nose in Older Children:**
- Use saline (salt water) nose drops or spray to loosen up the dried mucus. If you don't have saline, you can use a few drops of bottled water or clean tap water. Teens can just splash a little tap water in the nose and then blow.
 - **Step 1:** Put 3 drops per nostril.
 - **Step 2:** Blow each nostril out while closing off the other nostril. Then do other side.
 - **Step 3:** Repeat nose drops and blowing until the discharge is clear.
 - How Often: Do nasal saline whenever your child can't breathe through the nose.
 - Saline nose drops or spray can be bought in any drugstore. No prescription is needed.
 - Reason for nose drops: Nose blowing alone can't remove dried or sticky mucus.
 - Other option: Use a warm shower to loosen mucus. Breathe in the moist air, then blow each nostril.
25. **Decongestant Nose Spray (No prescription needed) for 12 years and older:**
- Use this only if the sinus still seems blocked up after nasal washes **And** age 12 years or older. Use the long-acting type (e.g., Afrin).
 - Dose: 1 spray on each side 2 times/day.
 - Always clean out the nose before using.
 - Use routinely for one day, thereafter only for symptoms. Don't use for more than 3 days. (Reason: rebound congestion.)
26. **Antihistamines for Nasal Allergies:**
- Antihistamines can bring an allergic cough and nasal allergy symptoms under control within 2 hours.
 - Long-Acting (LA) antihistamines, such as (e.g., Zyrtec or store brand cetirizine) that last up to 24 hours are preferred. Age limit: 6 months and older.
 - Canada: Zyrtec is Reactine.
 - Cetirizine dosing for 6 months to 2 years: 2.5 mL every 24 hours. For 2 years and older, follow package directions for dosing.
 - The key to hay fever control is to give antihistamines every day during pollen season.
27. **Pain Medicine:**
- To relieve chest pain, give acetaminophen every 4 hours **Or** ibuprofen every 6 hours. (See Dosage table.)
28. **Call Back If**
- Fever occurs (rectal temp 100.4 F or 38.0 C or higher)
 - Trouble breathing occurs
 - Wheezing occurs
 - Cough becomes worse
 - Your child becomes worse
29. **Cough Medicines:**
- Cough medicines should not be used until your child is at least 6 years of age.
30. **Warm Mist for Coughing Spasms:**
- For coughing spasms, expose to warm mist (e.g., in foggy bathroom). (Reason: relaxes the airway and loosens the phlegm.)
31. **Cover Your Child's Mouth When Coughing:**
- Loosely cover your child's mouth and nose with a disposable tissue (e.g., Kleenex, toilet paper, paper towel) or wash cloth.
 - Ask for a "surgical mask" upon arrival in doctor's office.

32. **Reassurance and Education:**
- Pollens usually cause a reaction in the nose and eyes.
 - Some children with hay fever have a cough as their main symptom.
 - Treatment of the nasal symptoms usually also brings the cough under control.
33. **Homemade Cough Medicine:**
- Goal: Decrease the irritation or tickle in the throat that causes a dry cough.
 - You can use these home remedies in addition to an antihistamine.
 - AGE 1 year and older: Use HONEY ½ to 1 teaspoon (2-5 ml) as needed. It works as a homemade cough medicine. It can thin the secretions and loosen the cough. If you don't have any honey, you can use corn syrup. Caution: Do not use honey until 1 year old.
 - AGE 6 years and older: Use COUGH DROPS to decrease the tickle in the throat. If you don't have any, you can use hard candy.
34. **Call Back If:**
- Allergic cough not improved after 2 days on antihistamines
 - Wheezing occurs
 - Your child becomes worse
35. **Call Back If**
- Continuous cough persists over 2 hours after cough treatment
 - Trouble breathing occurs
 - Wheezing occurs
 - Your child becomes worse
36. **Alternate Disposition - Call PCP in 24 Hours:**
- Between the hours of 10 PM to 6 AM, if the symptoms sound very mild and the child has NO fever, ask the caller to call back after 6 AM to speak to the MD.
37. **Call Back If:**
- Trouble breathing occurs
 - Fever develops (if hasn't had fever)
 - Your child becomes worse in any way
38. **Contagiousness/Return to School:**
- Your child can return to daycare or school after the fever is gone and your child feels well enough to participate in normal activities.
 - For practical purposes, the spread of coughs and colds cannot be prevented.
39. **Vaping Message:**
- Talk with your child about the dangers of vaping.
 - Vaping can cause severe lung injury. The lung damage can be permanent.
 - Vaping can even cause death. (50 in the US in 2019)
 - Vaping tobacco also causes nicotine addiction.
 - The legal age to purchase vaping products is 21 in the US (federal law).
 - Encourage your teen to avoid vaping. If they have started, urge them to quit.
 - Warning: Never use home-made or street purchased vaping solutions. Reason: they have caused most lung damage.

40. **Vomiting Medicines during Coughing Fits:**
- For medicines that are vomited during coughing, give them again when coughing is under better control.
 - If vomited prescription medicine due to coughing, repeat the dose if given within the last 60 minutes.
 - For over-the-counter medications, use nurse judgment whether repeat dose is needed or not. May repeat vomited dose once within the last 60 minutes.
50. **Call EMS 911 Now:**
- Your child needs immediate medical attention. You need to hang up and call 911 (or an ambulance).
 - Triager Discretion: I'll call you back in a few minutes to be sure you were able to reach them.
51. **Go To ED Now:**
- Your child needs to be seen in the Emergency Department immediately.
 - Go to the ED at _____ Hospital.
 - Leave now. Drive carefully.
52. **Go To ED/UCC Now (or PCP Triage):**
- **If No PCP (Primary Care Provider) Second-Level Triage:** Your child needs to be seen within the next hour. Go to the ED/UCC at _____ Hospital. Leave as soon as you can.
 - **If PCP Second-Level Triage Required:** Your child may need to be seen. Your doctor (or NP/PA) will want to talk with you to decide what's best. I'll page the on-call provider now. If you haven't heard from the provider (or me) within 30 minutes, go directly to the ED/UCC at _____ Hospital.
- Sources of Care:**
- **Triager Caution:** In selecting the most appropriate care site, you must consider both the severity of the patient's symptoms AND what resources are available at that care site.
 - **ED:** Patients who may need surgery, need hospitalization, sound seriously ill or may be unstable need to be sent to an ED. Likewise, so do most patients with complex medical problems and serious symptoms.
 - **UCC is Open:** Some Urgent Care Centers (UCCs) can manage patients who are stable and have less serious symptoms (e.g., minor illnesses and injuries). The triager must know the UCC capabilities before sending a patient there. If unsure, call ahead.
 - **Office is Open:** If patient sounds stable and not seriously ill, consult PCP (or follow your office policy) to see if patient can be seen NOW in office.

53. **See HCP (or PCP Triage) Within 4 Hours:**
- **If Office Will Be Open:** Your child needs to be seen within the next 3 or 4 hours. Call your doctor's (or NP/PA) office as soon as it opens.
 - **If Office Will Be Closed and No PCP (Primary Care Provider) Second-Level Triage:** Your child needs to be seen within the next 3 or 4 hours. A nearby Urgent Care Center (UCC) is often a good source of care. Another choice is to go to the ED. Go sooner if your child becomes worse.
 - **If Office Will Be Closed and PCP Second-Level Triage Required:** Your child may need to be seen. Your doctor (or NP/PA) will want to talk with you to decide what's best. I'll page the on-call provider now. If you haven't heard from the provider (or me) within 30 minutes, call again. **Note:** If on-call provider can't be reached, send to UCC or ED.
- Note to Triager:**
- Use nurse judgment to select the most appropriate source of care.
 - Consider both the urgency of the patient's symptoms AND what resources may be needed to evaluate and manage the patient.
- Sources of Care:**
- **ED:** Patients who may need surgery or hospital admission need to be sent to an ED. So do most patients with serious symptoms or complex medical problems.
 - **UCC:** Some UCCs can manage patients who are stable and have less serious symptoms (e.g., minor illnesses and injuries). The triager must know the UCC capabilities before sending a patient there. If unsure, call ahead.
 - **OFFICE:** If patient sounds stable and not seriously ill, consult PCP (or follow your office policy) to see if patient can be seen NOW in office.
54. **See PCP Within 24 Hours:**
- **If Office Will Be Open:** Your child needs to be examined within the next 24 hours. Call your child's doctor (or NP/PA) when the office opens and make an appointment.
 - **If Office Will Be Closed:** Your child needs to be examined within the next 24 hours. A clinic or an urgent care center is often a good source of care if your doctor's office is closed or you can't get an appointment.
 - **If Patient Has No PCP:** Refer patient to a clinic or urgent care center. Also try to help caller find a PCP (medical home) for future care.
- Note to Triager:**
- Use nurse judgment to select the most appropriate source of care.
 - Consider both the urgency of the patient's symptoms AND what resources may be needed to evaluate and manage the patient.
55. **See PCP Within 3 Days:**
- Your child needs to be examined within 2 or 3 days.
 - **PCP Visit:** Call your doctor (or NP/PA) during regular office hours and make an appointment. A clinic or urgent care center are good places to go for care if your doctor's office is closed or you can't get an appointment. **Note:** If office will be open tomorrow, tell caller to call then, not in 3 days.
 - **If Patient Has No PCP (Primary Care Provider):** Try to help caller find a PCP for future care (e.g., use a physician referral line). Having a PCP or "medical home" means better long-term care.

56. **See PCP Within 2 Weeks:**
- Your child needs an evaluation for this ongoing problem within the next 2 weeks.
 - **PCP Visit:** Call your child's doctor (or NP/PA) during regular office hours and make an appointment.
 - **If Patient Has No PCP (Primary Care Provider):** A primary care clinic is where you need to be seen for chronic health problems. **Note:** Try to help caller find a PCP (e.g., use a physician referral line). Having a PCP or 'medical home' means better long-term care.
58. **Home Care:**
- You should be able to treat this at home.
59. **Call PCP Now:**
- You need to discuss this with your child's doctor (or NP/PA).
 - I'll page the on-call provider now. If you haven't heard from the provider (or me) within 30 minutes, call again.
60. **Call PCP Within 24 Hours:**
- You need to discuss this with your child's doctor (or NP/PA) within the next 24 hours.
 - **If Office Will Be Open:** Call the office when it opens tomorrow morning.
 - **If Office Will Be Closed:** I'll page the on-call provider now. Exception: From 9 pm to 9 am. Since this isn't urgent, we'll hold the page until morning.
61. **Call PCP When Office Is Open:**
- You need to discuss this with your child's doctor (or NP/PA) within the next few days.
 - Call the office when it is open.

FIRST AID



N/A

BACKGROUND INFORMATION

Causes of Cough

- **Common Cold.** Most coughs are part of a cold that includes the lower airway. The medical name is viral bronchitis. The bronchi are the lower part of the airway that go to the lungs. Bronchitis in children is always caused by a virus. This includes cold viruses, influenza and croup. Bacteria do not cause bronchitis in healthy children. The common cold is the single most common cause of acute cough (i.e., cough less than 3 weeks in duration).
- **Sinus Infection.** The exact mechanism is unknown. It may be that post-nasal drip irritates the lower throat. Or pressure within the sinus may trigger the cough reflex.
- **Allergic Cough.** Some children get a cough from breathing in an allergic substance. Examples are pollens or cats. Allergic coughs can be controlled with allergy medicines, such as Benadryl.
- **Asthma.** Asthma is the most common cause of chronic coughs in children. In adults, it's smoking. Some 25% of children with asthma only cough and never wheeze (called cough variant asthma). They respond best to antihistamines or inhaled steroids.
- **Air Pollution Cough.** Fumes of any kind can irritate the airway and cause a cough. Tobacco smoke is the most common example. Others are auto exhaust, smog and paint fumes.
- **Exercise Induced Cough.** Running will make most coughs worse. If the air is cold or polluted, coughing is even more likely.
- **Whooping Cough (Pertussis) (Serious)** causes 2 - 6 weeks of paroxysmal coughing with post-

tussive emesis. The pertussis cough has distinguishing features. The child appears to be choking or suffocating. Ten or more coughs occur for each breath. The choking lasts for 1 to 2 minutes. In 50% of cases, the coughing attack ends with a whoop (like stridor). Between the coughing attacks, the child acts perfectly well. To teach pertussis recognition, go to the sound files on www.whoopingcough.net under symptoms (and sounds).

- **Serious Causes.** Pneumonia, bronchiolitis, and airway foreign body

Matching Pediatric Handouts for Callers

Printed home care advice instructions for patients have been written for this guideline. If your software contains them, they can be sent to the caller at the end of your call. Here are the names of the pediatric handouts that relate to this topic:

- Cough - Allergic
- Cough - Viral (Age 0-5)
- Cough - Viral (Age 6-21)
- Cough - Symptom (Age 0-5)
- Cough - Symptom (Age 6-21)
- Coughs and Colds: Medicines or Home Remedies?
- Fever - How to Take the Temperature
- Fever - Myths Versus Facts
- Acetaminophen (Tylenol) Dosage Table - Children
- Ibuprofen (Advil, Motrin) Dosage Table - Children

Cough Versus Croup Guideline: Tips

- For stridor, use the Croup guideline.
- For a barking cough with croup prevalent in the community, use the Croup guideline.
- For a barking cough with constant hoarseness, use the Croup guideline.
- For all other "maybe barking" coughs, use the Cough guideline.

Cough Variant Asthma

- Asthma is the most common cause of chronic cough in children.
- Some 25% of children with asthma only cough and never wheeze (called cough variant asthma).
- The cough is usually dry (nonproductive). Coughing spells can come on suddenly.
- The coughing spells have the same triggers as asthma attacks.
- The lung exam and all asthma tests are normal.
- Cough variant asthma is treated with asthma meds. It responds best to inhaled steroids. Antihistamines sometimes help.

Sputum or Phlegm

- The presence of purulent sputum is a poor predictor of whether an infection is caused by a viral or bacterial respiratory infection.
- Yellow or green phlegm is a normal part of the healing process of viral tracheitis or bronchitis.
- This means the lining of the trachea was damaged by the viral infection and is being coughed up as new mucosa replaces it.
- Bacteria do not cause tracheitis or bronchitis in healthy children. Antibiotics are not indicated for the viral bronchitis seen with colds.
- The main treatment of a productive cough is to facilitate it with good fluid intake, a humidifier (if the air is dry) and warm chicken broth or apple juice for coughing spasms (if over age 1).
- Cough accounts for more visits to HCPs than any other symptom. Needless worry about productive coughs may be the underlying cause of these unnecessary visits.

Productive Coughs Don't Help with Etiology

- Dry coughs usually turn into wet (productive) coughs during the course of a lower respiratory tract infection.
- Few coughs remain only dry or only wet.
- The amount of mucus production does not help determine etiology.
- There are no nonproductive cough organisms or productive cough organisms.
- That is why there are no separate Productive Cough and Non-Productive Cough guidelines.

Coughing up Blood-Tinged (Blood-Strreaked) Sputum

- In adults, coughing up blood-tinged sputum is serious until proven otherwise. Lung cancer, pulmonary emboli and such must be considered.
- In normal children, coughing up blood-tinged sputum is rare. When it happens, it's usually benign and transient.
- It mainly occurs in teens with a forceful hacking cough (or coughing fits) that damages the larynx or trachea (a micro-tear). If it only occurs a few times, the patient does not need to be seen.
- Because this "reason for call" is rare in pediatrics, this triage question is not included in all the respiratory guidelines.
- Safety of this decision: It is unlikely that a parent or patient would not spontaneously mention their concern about any blood seen in the sputum. The triage inquiry needs to focus on recognizing respiratory distress. In addition, there often are too many triage questions for triage nurses to ask in the respiratory guidelines
- Hopefully, this perspective explains why a coughing up blood question is only included in a few guidelines. (such as Cough)

Congestion - Types

- Congestion means different things to different people. None of the causes are usually urgent. Ask a few questions to determine which of the following 4 guidelines would be most helpful:
- **Colds:** for nasal congestion; a common problem for infants
- **Cough:** for chest congestion or "rattles" (vibrations) in the chest
- **Ear Congestion:** for a blocked ear, muffled hearing or ear popping sensation
- **Sinus Pain or Congestion:** for a blocked sinus, sinus pressure or head congestion

Respiratory Distress (Breathing Difficulty): Estimation By Telephone

- **Mild Respiratory Distress:** usually manifested by a rapid respiratory rate (tachypnea) (defined below). Mild stridor or wheezing may also be present. (Response: See Within 24 Hours, urgency varies)
- **Moderate Respiratory Distress:** manifested by labored breathing with some retractions and nasal flaring. If present, stridor and wheezing are now audible, tight and persistent (i.e. can hear over the telephone). (Disposition: Go to ED Now by car)
- **Severe Respiratory Distress:** marked respiratory effort (struggling to breathe) and severe retractions. Cyanosis may occur. Breathing may stop (apnea). The other extreme is the slow, weak breathing (agonal breathing) that precedes apnea. (Disposition for all of these: Call EMS 911 Now)

Life-Threatening Types of Severe Respiratory Distress

- **Apneic Episodes:** Apnea means that breathing stops for 20 seconds or longer. Prolonged apnea leads to loss of consciousness (hypoxic syncope) and is always a very serious symptom. All of these children need to be referred immediately via 911. Most of them are infants or young toddlers. Many of them have a viral respiratory infection. Etiologies commonly associated with apneic spells are RSV, pertussis, and Chlamydia.
- **Slow, Weak, Shallow Breathing:** This type of breathing precedes apneic spells. It is also called

agonal breathing. It is seen in children with respiratory failure following prolonged dyspnea. It is also seen with sepsis, increased intracranial pressure, poisoning and drug overdose.

- **Stridor:** Stridor is a harsh, raspy, low-pitched sound heard during inspiration (breathing in). It's commonly associated with retractions and great effort at trying to breathe in. The abrupt onset of stridor (upper airway obstruction) is seen with laryngeal foreign bodies, epiglottitis and anaphylaxis, as well as croup.

Rapid Respiratory Rates (RR) Due to Mild Respiratory Distress

- Tachypnea is usually the earliest sign of respiratory distress.
- Normal RR for children depend on their age.
- RR apply to children who are not crying. When upset or crying, RR normally go up 10 to 20 breaths per minute.
- If the RR is high and the child seems well, recheck the RR while he is asleep.
- The following RR are abnormally fast:
 - 2 months or younger: > 60 breaths per minute
 - 2 to 12 months: > 50 breaths per minute
 - 1 to 5 years: > 40 breaths per minute
 - 6 to 11 years: > 30 breaths per minute
 - 12 years or older: > 20 breaths per minute

Rapid Respiratory Rates (RR) Should Not Be Attributed to Fever

- Obviously, never attribute work of breathing (such as retractions or tight breathing) to fever.
- For safe triage, also do not attribute an abnormal RR (isolated tachypnea without dyspnea) to fever. Reason: risk of missing early respiratory distress and hypoxia, especially in bronchiolitis.
- Fever and RR: Although high fevers can cause small increases in RR, there is no reliable conversion factor.
- RR Assessment: RR is difficult to assess over the phone. Caller reports of "fast breathing" are also unreliable unless measured.
- Nurse judgment exception: If the fever is above 103 F (39.5 C) and the RR is slightly increased above abnormal (and not associated with any increased work of breathing or trouble feeding), a nurse may elect to provide a follow-up call in 1 hour. During that time, the caller will be instructed on how to lower the fever and how to better count the RR. Again, if in doubt or if time-consuming, refer the patient in for an exam and pulse oxygen saturation check.
- This recommendation was reviewed and approved by 4 pediatric pulmonologists at CHCO in 6/2019.

Assessing (Counting) Respiratory Rate (RR): When is it Indicated?

- Pros: Our QI study demonstrated that telehealth nursing assessment of tachypnea was confirmed by ED nursing assessment over 60% of the time. (Massaro 8/2017). This triage question referred in patients with viral bronchiolitis and pneumonia who otherwise might have been missed.
- Con: the parent's cooperation and instruction for counting RR can be time-consuming for the nurse. Our standard is to count respirations for 30 seconds and multiply by 2.
- Indications for assessing RR by phone:
 - When asked, the caller states that yes, the patient is "breathing fast".
 - In addition, the triage nurse did not hear any signs of respiratory distress when briefly listening to the patient at the start of the call. This is very important for patients under 2 years old with a cough.
 - In addition, the patient did not have a higher level positive triage question that already required the patient needed to be seen. In other words, the caller denies stridor, wheezing, retractions or any signs of respiratory distress.

Trouble Breathing: How to Discuss Respiratory Distress with Callers

- Trouble breathing (respiratory distress) is a reason to see a doctor right away.

- Here are symptoms to worry about:
- Struggling for each breath or shortness of breath
- Tight breathing so that your child can barely speak or cry
- Ribs are pulling in with each breath (called retractions)
- Breathing has become noisy (such as wheezes)
- Lips or face turn a blue color

Determining the Viral Etiology of Respiratory Infections

Specific respiratory symptoms such as hoarseness, stridor, type of cough, wheezing are not helpful for telling us the cause of the infection. All the lower respiratory tract viruses can cause croup, bronchiolitis or pneumonia symptoms. Influenza virus, COVID virus, respiratory syncytial virus and other viruses can cause the same clinical picture. In addition, getting an infection with 2 of these viruses within the same week can cause a higher complication rate. Reason: the first viral infection damages the lung tissue and makes it easier for the second virus to cause greater damage. That is why gaining protection from the flu vaccine reduces the risk a serious coronavirus infection. Viral tests are the only way to know for sure which virus is causing the child's symptoms and if quarantine is needed. On the downside, the tests can be expensive.

Coughs and How They Sound

Caution: Cough characteristics generally are not helpful at telling us if the cause is serious. Asking about difficulty breathing or respiratory distress is the only way to determine seriousness. Coughs are also not helpful at determining etiology, except the barky cough of croup is fairly distinctive. The sound of the cough in patients can vary greatly over the course of the day. A rattly cough is simply a productive cough. The chest wall usually vibrates if you feel it during a bout of coughing. Describing the cough itself does not usually help with decision making.

Continuous or Nonstop Coughing: How to Define

- Caution: Don't directly ask the caller, "Is the coughing continuous or nonstop?" You will commonly trigger a positive response that is false. Instead, ask questions about what the cough keeps the child from doing (function).
- **First:** To qualify as continuous coughing, the coughing needs to greatly interfere with function in the following areas: sleeping, taking fluids and playing.
- **Sleep:** The baby or child is not able to sleep for more than a 30 minutes at a time. Then, he's fully awake crying and coughing again. Coughing during sleep does not count.
- **Fluid Intake:** Coughing should interfere with fluid intake. The baby or child cannot drink adequate fluids due to coughing. In babies, formula intake is less than half of normal intake. Recent research found this to be associated with hypoxia.
- **Play:** The baby or child is not able to play or do normal activity due to coughing.
- **Second:** Severe, tight, frequent coughing should be heard at the time of the call. In fact, for any respiratory call about a child less than 2 years old, our policy is that the nurse needs to listen to the child's breathing over the phone. Listening early in assessment may help reduce call time. It also helps to accurately assess the child leading to the most appropriate disposition decision.
- **Third:** The baby or child must fail to improve on standard treatment advice before referring them to be seen urgently. That means they have already tried warm fluids, honey (if 1 year or older), warm mist, nasal suctioning with saline drops (for babies/young children). It also means these interventions have not helped the cough at all. If partial or no home care has been tried, the nurse should proceed in triage and bypass the continuous coughing question.
- Reasons for seeing these children with continuous coughing: Many of them are hypoxic, especially if they are infants.

Cough and Cold Medicines: FDA Recommendation (October 2008)

In October 2007, the AAP and other experts testified before the FDA about the safety of cough and

cold medicines for young children. According to FDA data from 1969 to 2006, adverse reactions included 54 deaths from decongestants and 69 deaths from antihistamines. To put this in perspective, that's 3.3 reported deaths per year. The majority occurred in children younger than 2 years of age. In January 2008, the FDA issued a strong recommendation that parents "not use OTC cough and cold products to treat infants and children less than 2 years of age". In October 2008, the FDA changed the cutoff to 6 years of age. These recommendations have been implemented within the related guidelines. In addition, the information has been added to all the Dosage Tables for OTC medicines.

- Under 6 years of age (Canada: also 6 years): advise callers that OTC cough and cold medicines should never be used in this age group because of potential serious side effects. They also lack efficacy. (FDA recommendation--October 2008)
- Over 6 years of age: advise callers that the best treatment for coughs is honey or cough drops. The best treatment for nasal congestion is nasal washes with saline drops or spray. However, if a parent wants to use a cough or cold medicine, help them calculate a safe dosage. (FDA advisory panel has no recommendation at this time)
- For all ages, discourage the use of multiple-ingredient cough and cold medicines. (Reason: risk of overdosage).

Honey as a Cough Syrup: Proven Efficacy

- A 2007 study compared the efficacy of honey to DM to no treatment for nocturnal coughing.
- Honey consistently scored the best for reducing cough frequency and cough severity. It also scored best for improving sleep.
- DM did not score significantly better than no treatment at all.
- The study group contained 105 children age 2 to 18 years.
- The dose of honey used was ½ tsp (2 ml) for 2-5 year-olds, 1 teaspoon for 6 to 11 year-olds, and 2 tsp for 12 to 18 year-olds. A single dose was given at bedtime.
- One explanation for how honey works is that sweet substances naturally cause reflex salivation and increased airway secretions. These secretions may lubricate the airway and remove the trigger (or tickle) that causes a dry, nonproductive cough.
- Paul IM. Arch Pediatr Adolesc Med. 2007; 161(12):1140-1146.
- A 2012 study compared the efficacy of honey to a placebo.
- Honey showed the most improvement in cough frequency and severity during the night.
- Study group: 300 children age 1 to 5 years.
- Dosage of honey: 10 ml given as a single dose 30 minutes before bedtime.
- Cohen HA. Pediatrics 2012; 130:465-471.

Honey and Infantile Botulism

- Honey has a small association with infantile botulism
- Mechanism: Clostridium botulinum spores are present in some honey products
- Age at onset: 1 to 44 weeks (median: 15 weeks)
- Incubation period after consuming spores: 3-30 days
- Presenting symptoms: constipation, weak suck, weak cry, ptosis, droopy face. Progresses to generalized weakness.
- Prevalence of infantile botulism: 91 cases were reported in the US in 2007.
- Cause: Honey is a minor cause. Approximately 10% of cases of infantile botulism are associated with honey. The other 90% are either idiopathic or associated with blowing dust (especially in areas of active housing development). Botulism spores are found ubiquitously in all soil. They are also present fairly uniformly in vacuum cleaner contents.
- Therefore, honey is not recommended for any child less than 12 months of age in these guidelines for any symptom.

Corn Syrup as a Cough Syrup: No Risk for Botulism (2010)

- 2010 Care Advice change: Corn syrup has been added back as an option for a homemade cough syrup in children less than 1 year of age. Since honey has proven efficacy, corn syrup may share similar properties. (Note: corn syrup lacks evidence for efficacy). However, to keep the telephone advice compatible with office advice, corn syrup should only be mentioned if the parent complains that the cough is severe and nothing previously recommended has helped.
- Safety: In 2009, the AAP, CDC and Health Canada websites all continue to recommend avoiding honey in infants less than 1 year old. (Reason: risk of infant botulism) However, none of these websites mention any concerns about corn syrup or the need to avoid it in infants.
- We need to keep in mind that all infants who were not breastfed between 1940 and approximately 1970 received evaporated milk (EM) formulas that included corn syrup in their preparation (13 oz. EM, 19 oz. water and 2 Tbsp. corn syrup). Also, dark corn syrup has been used to treat constipated infants for generations. (Note: also lacks evidence for efficacy)
- The 2006 and 2009 AAP Red Book states clearly that “no case of infant botulism has proved to be attributable to consumption of corn syrup”.

Agave Nectar as a Cough Syrup

- Agave nectar has been studied as a potential cough syrup for treating nocturnal cough.
- It was compared to a placebo (grape-flavored water) and to no treatment.
- Age range of the 119 patients: 2 months to 2 years.
- Results: agave nectar showed significant reduction in cough frequency and severity compared to no treatment. However, the placebo (grape-flavored water) gave similar results.
- Current recommendation in this guideline: use warm apple juice as a cough syrup during the first year of life. Likely it is also a placebo and should give similar results to grape-flavored water.
- Advantage of apple juice over agave nectar: easier to find in the store and less expensive.
- Lesson: Parents perceive improvement in their child's cough if given a reasonable placebo. Telling them that no treatment is necessary is a disservice and may lead to seeking additional care or requesting prescription meds elsewhere.
- Reference: Paul I, JAMA Pediatr. 2014

Home Remedies for Infants

- Giving apple juice or corn syrup for cough are not evidence based.
- But both are safe, unlike OTC cough medicines.
- The warm apple juice has been in the Cough protocol since 2000.
- It was added for parents who want to be giving their baby something. It may have placebo value.
- The corn syrup is a safe replacement for honey. Honey (for children over age 1) of course has 2 published studies to support its efficacy.
- Please read the Background Information in this guideline for details.
- If the reader has a more effective home treatment for cough, please share it with the author.

Dextromethorphan Cough Medicines For Cough

- The most common cough suppressant in OTC cough medications is dextromethorphan. Usually the letters "DM" appear in the name. An example is Robitussin DM.
- Some research (Kelly 2004) suggests that dextromethorphan is no better than placebo at reducing the severity and frequency of coughing in children.
- The care advice in these guidelines continues to support DM containing cough syrups for children over 6 years of age with SEVERE COUGHS if the caller insists on using one. The rationale for this is: patients may benefit from the placebo effect of DM, many parents demand a recommendation for a cough syrup even after being told about honey, and generally DM has no side effects.
- Cough drops can often be substituted for cough syrups after age 6. While some would consider them a placebo similar to cough medicines, they may actually reduce coughing by soothing an irritated throat. In addition they have the advantage of portability. While cough drops with DM are available, they offer no advantage over plain cough drops and are not worth the added expense.

- It is important to note that dextromethorphan has become a drug of abuse. This problem has been seen most commonly in the adolescent population. Overdose symptoms can range from giggling, euphoria, to hallucinations or coma. (See Substance Abuse guideline for details)

Codeine Medications for Coughs: Never Recommended in Children and Teens

- Prescription cough syrups containing codeine have long been available. They are available OTC in some states.
- An FDA advisory panel (2015) recommended that codeine not be used for the treatment of cough in children under the age of 18. Also, do not prescribe codeine products to breastfeeding mothers.
- Reasons to not use: risk of serious side effects. In overdose, it has the unpredictable risk of respiratory depression, slowed breathing and respiratory arrest. Mechanism: Some patients have the gene to rapidly convert codeine to morphine. Also, codeine and hydrocodone are opioids. Exposure to opioid drugs can increase the risk of future opioid addiction.
- Resource: Tobias JD. AAP Committee on Drugs. Pediatrics 2016.

Cough Drops and Choking Risk

- Cough drops and throat lozenges pose the same choking risk for young children as hard candy.
- At age 4 years, candy (hard and other) accounts for 55% of choking episodes.
- The frequency of choking episodes by age trends downward until age 7 years.
- The Schmitt guidelines recommend 6 years and above as a cutoff for using cough drops. This is the policy in Canada. The AAP currently (2013) uses age 4 as a cutoff.
- Some hot dog manufacturers currently recommend age 6 years for eating their products.
- Resource: Gary Smith MD, FAAP

Vapor Rub and Coughs: Questionable Value

- Vick's Vapor Rub (VR) active ingredients are camphor 4.8% and menthol 2.6%.
- Intervention group: VR applied to upper chest and neck 30 minutes before bedtime.
- Control group: petrolatum applied in same manner.
- Subjects: 2 to 11 years old (N=44 and 47 respectively) with coughs and colds. Excluded children with croup, asthma or any chronic lung disease.
- Method: survey questionnaire to assess nocturnal symptoms was completed by parent on following morning.
- Results: cough severity (p=.06), cough frequency (p=.07), nasal congestion (p=NS), child's ability to sleep (p=.006). Only side effects: skin burning sensation in 30% and skin rash in 5%.
- Clinical significance: questionable.
- Guideline application: None. Honey for coughs and saline for nasal congestion are evidenced-based. VR is not. So, don't bring it up.
- If caller asks about VR, tell them: Can approve applying a small amount of VR to the chest wall once at bedtime, but no proven benefit. Can be used if other methods fail and child is healthy and over 2 years of age. (Reason: concerns about camphor toxicity in younger children. Poison centers receive 10,000 calls per year about camphor exposure).
- Avoid use if child has asthma or develops wheezing or a croupy cough.
- Avoid using VR in vaporizers or in the nose.
- Note: Each call center and medical director need to decide whether or not to approve the use of this product as described.
- Resource: Paul IM. Pediatrics 2010; 126:1092-1099

Antibiotics for Cough

- Acute Bronchitis: In healthy people, acute bronchitis is viral and part of a cold. Antibiotic therapy provides no benefit. There is no effect on duration of illness, severity of symptoms or return to school.
- Common Cold: Colds are caused by viruses. No medicine, "shot", or antibiotic will cure an

uncomplicated cold.

- Pneumonia: Pneumonia in childhood is 90% viral and 10% bacterial. Antibiotic therapy is only helpful for bacterial pneumonia.
- Whooping Cough (Pertussis): Whooping cough is caused by a bacteria (*Bordetella pertussis*). Treatment with antibiotics is indicated when whooping cough is diagnosed.

Birth To 3 Months Old: Indications For Seeing Patients Immediately With Fever

- The triage question, "Age < 12 weeks AND fever 100.4 F (38.0 C) or higher rectally", is found in multiple symptom-based and newborn guidelines.
- Rectal temperatures are preferred before sending babies into the Emergency Room. (Reason: EDs/offices perform rectal readings to guide ED work-ups). If a caller is unable to take a rectal temp, the following definitions of fever can apply to this question as well:
 - Rectal or Temporal Artery temperature: 100.4 F (38.0 C) or higher
 - Pacifier temperature: 100 F (37.8 C) or higher
 - Axillary (armpit) temperature: 99 F (37.2 C) or higher
 - Tympanic temperatures are not reliable before 6 months of age.
 - Temporal artery and skin infrared temperatures may be reliable in young infants. (De Curtis 2008)
 - Note: Rectal temperatures always preferred over axillary readings (Reason: axillary often inaccurate). (EXCEPTION: Axillary temp above 100.4 F (38 C), just see them)

REFERENCES

1. Abuelgasim H, Albury C, Lee J. Effectiveness of honey for symptomatic relief in upper respiratory tract infections: a systematic review and meta-analysis. *BMJ Evidence-Based Medicine* Published Online First: 18 August 2020.
2. American Academy of Pediatrics, Committee on Drugs Use of codeine- and dextromethorphan-containing cough remedies in children. *Pediatrics*. 1997;99:918-919
3. Barker SJ. Honey for acute cough in children. *Paediatr Child Health*. 2016 May;21(4):199-200.
4. Blacklock C, Mayon-White R, Coad N, Thompson M. Which symptoms and clinical features correctly identify serious respiratory infection in children attending a paediatric assessment unit? *Arch Dis Child*. 2011 Aug;96(8):708-14.
5. Bradley JS, Byington CL, Shah SS, Pediatric Infectious Diseases Society, Infectious Diseases Society of America, et al. The management of community-acquired pneumonia in infants and children older than 3 months of age: clinical practice guidelines. *Clin Infect Dis*. 2011 Oct;53(7):e25-76.
6. Chang AB, Glomb WB. Guidelines for evaluating chronic cough in pediatrics: ACCP evidenced-based clinical practice guidelines. *Chest* 2006;129:260S.
7. Chang AB. American College of Chest Physicians cough guidelines for children. *Chest* 2008;134(6):1111-1112.
8. Cohen HA, Rozen J, Kristal H, et al. Effect of honey on nocturnal cough and sleep quality: a double-blind, randomized, placebo-controlled study. *Pediatrics*. 2012;130(3):465-471.
9. Cromer BA, Goydos J, Hackell J, et al. Unrecognized pertussis infections in adolescents. *Am J Dis Child*. 1993;147:575.
10. Ebell MH, Lundgren J, Youngpairoj S. How long does a cough last? Comparing patients' expectations with data from a systematic review of the literature. *Ann Fam Med*. 2013 Jan;11(1):5-13.

11. Farber HJ. New understanding of the health hazards of electronic cigarettes and vaping. *Pediatr Rev.* 2020 Mar;41(3):152-154.
12. Green JL, Wang GS, Reynolds KM, et al. Safety profile of cough and cold medication use in pediatrics. *Pediatrics.* 2017 Jun;139(6). pii: e20163070.
13. Guilbert TW, Taussig LM. "Doctor, he's been coughing for a month. Is it serious?" *Contemp Pediatr.* 1998;15(3):155-172.
14. Hampton LM, Nguyen DB, Edwards JR, et al. Cough and cold medication adverse events after market withdrawal and labeling revision. *Pediatrics.* 2013 Dec;132(6):1047-1054.
15. Hersh AL, Jackson MA, Hicks LA, and the AAP Committee on Infectious Diseases. Principles of judicious antibiotic prescribing for upper respiratory tract infections in pediatrics. *Pediatrics.* 2013 Dec;132(6):1146-1154.
16. Kelly LF. Pediatric cough and cold preparations. *Pediatr Rev.* 2004;25(4):115-123.
17. Kompare M, Weinberger M. Protracted bacterial bronchitis in young children: association with airway malacia. *J Pediatr.* 2012 Jan;160(1):88-92
18. Krafft C, Christy C. *Mycoplasma pneumonia* in children and adolescents. *Pediatr Rev.* 2020 Jan;41(1):12-19.
19. Lowry JA, Leeder JS. Over-the-counter medications: update on cough and cold preparations. *Pediatr Rev.* 2015 Jul;36(7):286-297.
20. Marchant JM et al. What is the burden of chronic cough for families? *Chest* 2008;134(2):303.
21. Margolis P and Gadomski A. Does this infant have pneumonia? *JAMA.* 1998; 279:308-314.
22. Masson V, Kier C, Chandran L. Cough conundrums: a guide to chronic cough in the pediatric patient. *Pediatr Rev.* 2022 Dec 1;43(12):691-703.
23. Mazer-Amirshahi M, Rasooly I, Brooks G, et al. The impact of pediatric labeling changes on prescribing patterns of cough and cold medications. *J Pediatr* 2014 Nov;165:1024-1028.
24. Neuman MI, Monuteaux MC, Scully KJ, et al: Prediction of pneumonia in a pediatric emergency department. *Pediatrics* 2011;128:246-253.
25. Nijman RG, Thompson M, van Veen M, et al. Derivation and validation of age and temperature specific reference values and centile charts to predict lower respiratory tract infection in children with fever. *BMJ.* 2012 Jul 3;345:e4224.
26. Olsen SJ, Swerdlow DL. Risk of infant botulism from corn syrup. *Pediatr Infect Dis J.* 2000;19:584.
27. Paul IM, Beiler JS, King TS, et al.: Vapor rub, petrolatum, and no treatment for children with nocturnal cough and cold symptoms. *Pediatrics* 2010;126:1092-1099.
28. Paul IM, Beiler JS, Vallati JR, et al. Placebo effect in the treatment of acute cough in infants and toddlers: a randomized clinical trial. *JAMA Pediatr.* 2014 Dec 1;168(12):1107-1113.
29. Paul IM; Beiler J, McMonagle A, et al. Effect of honey, dextromethorphan and no treatment on nocturnal cough and sleep quality for coughing children and their parents. *Arch Pediatr Adolesc Med.* 2007;161(12):1140-1144.
30. Paul, IM, Yoder KE, Crowell KR, et al. Effect of Dextromethorphan, Diphenhydramine, and placebo on nocturnal cough and sleep quality for coughing children and their parents. *Pediatrics.* 2004;114:e85-e90.

31. Porter P, Abeyratne U, Swarnkar V, et al. A prospective multicentre study testing the diagnostic accuracy of an automated cough sound centred analytic system. *Respir Res.* 2019 Jun 6;20(1):81.
32. Schaefer MK, Shehab N, Cohen AL, et al. Adverse events from cough and cold medications in children. *Pediatrics.* 2008;121(4):783-787.
33. Shah S, Bachur R, Kim D, Neuman MI. Lack of predictive value of tachypnea in the diagnosis of pneumonia in children. *Pediatr Infect Dis J.* 2010 May;29(5):406-409.
34. Shnayder R, Needleman JP. Hemoptysis. *Pediatr Rev.* 2018 Jun;39(6):319-321
35. Taylor JA, Novack AH, Almquist JR, Rogers JE. Efficacy of cough suppressants in children. *J Pediatr.* 1993;122:799-802.
36. Thompson M, Vodicka TA, Blair PS, et al. Duration of symptoms of respiratory tract infections in children: systematic review. *BMJ.* 2013;347:f7027.
37. Tobias JD, Green TP, Coté CJ; AAP Section on Anesthesiology and Pain Medicine, AAP Committee on Drugs. Codeine: Time to say "no". *Pediatrics.* 2016 Oct;138(4). pii: e20162396.
38. Traisman ES. Clinical evaluation of chronic cough in children. *Pediatr Ann.* 2015 Aug;44(8):303-307.
39. Tutor JD. Dysphagia and chronic pulmonary aspiration in children. *Pediatr Rev.* 2020 May;41(5):236-244.
40. Vo P, Kharasch VS. Respiratory failure. *Pediatr Rev.* 2014 Nov;35(11):476-486.
41. Wagner JB, Pine HS. Chronic cough in children. *Pediatr Clin North Am.* 2013 Aug;60(4):951-967.
42. Woods C. Acute bacterial pneumonia in childhood in the current era. *Pediatr Ann.* 2008;37(10):694-702.
43. Zgherea D, Pagala S, Mendiratta M, et al. Bronchoscopic findings in children with chronic wet cough. *Pediatrics.* 2012;129:e364-e369.

SEARCH WORDS

ALLERGIC REACTION
 ALLERGIES
 ALLERGY
 BLUE
 BRONCHITIS
 CHEST
 CHEST CONGESTION
 COUGH
 COUGHING
 COUGHING SPASMS
 COUGHING SPELLS
 COUGHING UP BLOOD
 COUGHING UP MUCUS
 COUGHS

CROUP
CYANOSIS
DEEP BREATHING
DRY COUGH
HEAVY BREATHING
LRI
LUNGS
PEDIATRIC
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