

## The First AAP Clinical Practice Guideline for Febrile Infants

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Nearly two decades in the making, the American Academy of Pediatrics (AAP) Clinical Practice Guideline for the Evaluation and Management of Well-Appearing Febrile Infants 8-60 Days Old is published in this month's issue of *Pediatrics* ([10.1542/peds.2021-052228](#)). With clinicians needing to balance the low but present risks of invasive bacterial infections against the risks of invasive procedures and hospitalizations, the management of febrile infants has been a challenge for decades. With much gratitude to the multi-disciplinary group of guideline authors and the AAP Subcommittee on Febrile Infants, led by Drs. Robert Pantell and Kenneth Roberts, clinicians now have an evidence-based guideline to guide - but not direct - their evaluation and management of febrile infants.

Please read the 21 key action statements, the 40 total recommendations, and the summaries of the evidence that led to these recommendations. To highlight a few notable points (among many) from the guideline:

- The guideline provides separate recommendations for infants 8-21 days, 22-28 days, and 29-60 days old.
- White blood cell count is not recommended for the risk stratification of febrile infants, while procalcitonin is recommended as part of algorithms such as the Pediatric Emergency Care Applied Research Network (PECARN) prediction rule. If procalcitonin is not available, the guideline recommends using height of fever in combination with absolute neutrophil count and c-reactive protein.
- Particularly for decisions about cerebrospinal fluid testing and disposition for infants 22-28 days old, the guideline incorporates recommendations for shared decision-making with parents.
- Urine culture is recommended for all age groups if the urinalysis is positive; this two-step process with the urine culture dependent on the urinalysis result may represent a change for many clinicians.
- Discharge at 24 or 36 hours is recommended for hospitalized infants of all age groups if cultures are negative and the infant is clinically improving.

Even with the publication of the AAP febrile infant clinical practice guidelines, there is additional work to be done. With ongoing research from several collaboratives, including the large prospective cohorts assembled by PECARN, the evidence will continue to evolve for the management of febrile infants. Clinicians must continue to stay updated as new research emerges. Additionally, local implementation of guideline recommendations will take effort and buy-in from stakeholders, and quality improvement initiatives such as the AAP-sponsored

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Reducing Excessive Variability in Infant Sepsis Evaluation (REVISE II) can help support these efforts. Finally, as the guideline authors eloquently write, some decisions will vary among clinicians based on risk tolerance and the incorporation of parents' values and preferences. Ultimately, the AAP febrile infant clinical practice guidelines will help guide clinicians and parents to make decisions for febrile infants informed by the best available evidence.

- [Testing for Meningitis in Febrile Well-Appearing Young Infants With a Positive Urinalysis](#)
- [Machine Learning To Predict Serious Bacterial Infections in Young Febrile Infants](#)
- [A Case Series of the 2019 Novel Coronavirus \(SARS-CoV-2\) in 3 Febrile Infants in New York](#)
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