

Guideline

Brief Resolved Unexplained Events (BRUE): Clinical Practice Guideline

An updated guideline for assessment and management of infants with the diagnosis formerly known as Apparent Life-Threatening Events (ALTE)

Document ID	CHQ-GDL-00746	Version no.	2.1	Approval date	26/02/2021
Executive sponsor	Executive Director Medical Services			Effective date	01/02/2024
Author/custodian	Director, Paediatric Emergency Department			Review date	26/02/2025
Supersedes	2.0				
Applicable to	Medical, Nursing and QAS Staff working in Children's Health Queensland				
Authorisation	Executive Director Clinical Services				

Purpose

This guideline has been developed to assist clinicians in the understanding of the definition, approach to patient evaluation, and management of children less than 1 year of age who present with BRUE (Brief Resolved Unexplained Events), formerly known as ALTE (Apparent Life Threatening Event).

Scope

This guideline applies to all staff involved in the care and management of children with BRUE

Guideline

Introduction

The American Academy of Pediatrics (AAP) published a new clinical practice guideline advocating for the replacement of the term Acute Life-Threatening Events (ALTE) with BRUE (brief, resolved, unexplained event) in May 2016.¹ ALTE was first introduced in 1986 replacing the term "near-miss sudden infant death syndrome".² However due to the subjective and imprecise nature of the definition of ALTE³, the AAP created a more precise definition for this group of clinical events and at the same time removed the more serious implication of the term 'life-threatening'. Subsequent research has shown decreased numbers of admission for BRUE diagnosis without an increase in ED representations or adverse outcomes.⁴

The most important aspect in suspected BRUE is to make the correct diagnosis for the episode following a thorough history and examination. The next step is to risk stratify the patients into low-risk or high-risk categories.

The AAP guideline provides a risk-based approach to diagnosis and evidence-based recommendations to reduce unnecessary investigations in the low-risk infant group. It is important to note however that the guideline does not provide management recommendations for the high-risk infant group due to lack of reliable research evidence at this time.

Definition

A BRUE is defined as an event occurring in an infant <1 year of age when the observer reports a sudden, brief, and now resolved episode of ≥ 1 of the following^{1,3}:

- Cyanosis or pallor
- Absent, decreased, or irregular breathing
- Marked change in tone (hypertonia or hypotonia)
- Altered level of responsiveness



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Clinicians should only diagnose a patient with BRUE after conducting a thorough history and physical examination and if there is still no explanation for the event.

See [Appendix 1: BRUE Definition and Inclusion/Exclusion Factors](#) for detailed definition of BRUE.

History and Examination

A thorough and complete history is important in differentiating BRUE from a more concerning event that may require more extensive investigation and monitoring. In addition, this also assists in stratifying what is a 'Low Risk BRUE' compared with a 'Higher Risk BRUE'.

It is important that the history and examination are performed by a doctor experienced in paediatric assessment, and ideally a Paediatric Emergency Medicine (PEM) or Paediatric Medicine Specialist or Fellow or senior trainee should review the patient and be involved in the decision on final disposition. If sufficiently experienced staff are not available, e.g., overnight, it would be reasonable to keep the patient for observation after discussion with a senior staff member or admit for reassessment by a senior staff member in the morning. If an experienced PEM or Paediatric Specialist or Fellow is unavailable, consultation with QCH ED SMO or ED SMO at major referral centre would be advisable to enable appropriate decision-making regarding diagnosis and disposition.



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Children who have been the victims of abusive or non-accidental injury (NAI) may present with altered episodes which could be mistaken as BRUE.

Specific consideration for child abuse should be given to all children with unexplained events including those with multiple or changing versions of the events and episodes that are not consistent with the child's developmental stage.

History

Key features

- Description of the event
 - Location of the event
 - Who was present
 - Preceding events
 - Relationship to feeding
- Symptoms noted during the event
 - Airway and Breathing
 - Choking or gagging
 - Colour change
 - Breathing effort
 - Circulation
 - Colour- central and peripheral
 - CNS
 - Movement
 - Conscious state
- Circumstances at resolution of the event
 - Total duration
 - How the event stopped
 - CPR performed

In addition to the above description of the event, a full systems review and paediatric history should be obtained including perinatal/birth history, immunisations, growth and development, social and family history as well as clarifying that this is the first similar event and no prior diagnosis of BRUE have been made.

See [Appendix 2: History Taking in the Assessment of Potential BRUE](#) for further information on history taking in the assessment of potential BRUE.

Examination

A full examination of the fully exposed infant is essential. This should aim to identify signs of possible differential diagnoses including consideration of NAI. A full set of vitals and growth parameters must be documented.

See [Appendix 3: Physical Examination in the Assessment of Potential BRUE](#) for further information on physical examination in the assessment of potential BRUE.

Risk Assessment: Low Risk BRUE versus High Risk BRUE

Once a diagnosis of BRUE is made, risk classification can be undertaken.

The factors that determine a 'Low Risk BRUE' include (must meet all criteria) ^{1,3}:

- Age > 60 days
- Gestational age ≥ 32 weeks and postconceptional age ≥ 45 weeks
- First BRUE (no prior BRUE and not occurring in clusters)
- Duration <1 minute
- No CPR by trained provider
- No Family history of BRUE or sudden unexplained death in a sibling
- No concerning physical findings

Patients who do not meet ALL the criteria above would be classified into the 'High Risk BRUE' group.

Please refer to [Appendix 4: BRUE Diagnosis & Risk Stratification Flowchart](#) for a flow diagram categorising events into low- or high-risk BRUE and to *Appendix* for list of differentials of low- and high-risk BRUE.

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The presence of the following warning signs increases the likelihood that the acute event is medically significant. Infants with these signs **should be admitted** to the hospital for observation with cardiorespiratory monitoring.

- Symptoms at the time of evaluation, including toxic appearance, lethargy, unexplained recurrent vomiting or respiratory distress.
- Significant physiological compromise during the event, based on a detailed history, including generalised sustained cyanosis or loss consciousness, and/or need for resuscitation by a trained provider.
- Bruising or any other evidence of trauma
- History of prior events in this patient, especially in the preceding 24 hours or clusters of events.
- History of clinically significant events or unexpected death of a sibling
- Administration or access to medication
- History raising suspicion for child abuse including inconsistent description of event.
- Dysmorphic features, congenital anomalies, including those suggestive of a known syndrome



Management

Low Risk BRUE

If the infant is categorised into the low-risk category, it is appropriate to not perform further investigations and dedicate time to educate and engage the parents in a shared decision-making process in terms of further management and follow up.

Depending on the level of clinical suspicion and parental anxiety in an otherwise low-risk category infant, it is appropriate to perform an electrocardiogram (ECG), Pertussis PCR (if exposure likely, unimmunised child, or no maternal antenatal booster), or monitor the infant for a short duration of 1-4 hours with continuous pulse oximetry and serial observations. [Appendix 4: BRUE Diagnosis & Risk Stratification Flowchart](#) outlines the American Academy of Pediatrics recommendations in regards to management options for infants with low-risk BRUE.

High Risk BRUE

Infants who are categorised into the high-risk group would require further management to delineate the aetiology of symptoms. The decision on the type of investigation, imaging, and specialist consultation depend on the history and physical examination as well as the social situation of the infant. All infants with a diagnosis of High Risk BRUE should be admitted under the General Paediatric team.

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There is no evidence to inform the management of High Risk BRUE.
These patients require a detailed plan which should be tailored to the individual case.
Paediatric opinion should be sought.

Disposition

The infant with a low-risk BRUE episode may be discharged home if both the caregiver and senior clinician with paediatric experience are comfortable with the plan. It is also reasonable to observe for a few hours or admit for further observation if the parent or clinician feels this is necessary.

Advocating for CPR training for parents and providing them with course resources is an important component of patient and family-centred care. CPR training enables the parents to have a sense of empowerment and has not been shown to increase parental anxiety.⁶

All infants discharged with a diagnosis of low-risk BRUE should be followed up by a General Practitioner (GP) or Paediatrician in 24 hours. The disposition of the infant with high-risk BRUE would depend on the aetiology and/or the diagnosis of the symptoms.

Consultation

Key stakeholders who reviewed this version:

- ED Fellow QCH Emergency Department
- ED SMOs QCH Emergency Department
- SMO QCH Paediatric Medicine

Definition of terms

Term	Definition
BRUE	An event occurring in an infant < 1 year when the observer reports a sudden, brief, and now resolved but unexplained episode of ≥ 1 of: (1) cyanosis or pallor; (2) absent, decreased or irregular breathing; (3) marked change in tone (hyper- or hypotonia); and (4) altered level of responsiveness.
ALTE	An episode that is frightening to the observer and that is characterized by some combination of apnoea (central or occasionally obstructive), colour change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking, or gagging.
AAP	The American Academy of Pediatrics
CPR	Cardiopulmonary Resuscitation

References and suggested reading

1. Tieder JS, Bonkowsky JL, Etzel RA et al. Clinical Practice Guideline: Brief resolved unexplained events (formerly apparent life-threatening events) and evaluation of lower-risk infants. *Pediatrics*. 2016;137 (5): e20160590.
2. National Institutes of Health Consensus Development Conference on Infantile Apnea and Home Monitoring, Sept 29 to Oct 1, 1986. *Pediatrics*. 1987;79(2):292.
3. Davis T. BRUE is the new black: Apparent life-threatening events in babies. www.dontforgetthebubbles.com.
4. Ramagopal S, Noorbaksh KA, Callaway CW, Wilson PA, Pitetti RD. Chnges in the Management of Children with Brief Resolved Unexplained Events (BRUEs). *Peditrics* 2019;144(4)e20190375
5. McLauchlan CA, Ward A, Murphy NM et al. Resuscitation training for cardiac patients and their relatives--its effect on anxiety. *Resuscitation*. 1992 Aug-Sep;24(1):7-11.
6. Tieder JS, Altman RL, Bonkowsky JL et al. Management of apparent life-threatening events in infants: A systematic review. *The Journal of Pediatric*. 2013;163 (1): 94-99.
7. www.uptodate-com. Acute events in infancy including brief resolved unexplained event (BRUE).
8. http://www.rch.org.au/clinicalguide/guideline_index/apparent_life_threatening_event_alte/

Guideline revision and approval history

Version No.	Modified by	Amendments authorised by	Approved by
1.0 20/02/2017	Director Paediatric Emergency Department	Divisional Director, Critical Care	Executive Director Hospital Services

Version No.	Modified by	Amendments authorised by	Approved by
2.0 01/02/2021	Director Paediatric Emergency Department	A/Division Director, Critical Care	Executive Director Clinical Services
2.0 01/02/2024 (Minor Change)	Governance Officer (Documents)	Paediatric Emergency Physician	Paediatric Emergency Physician

Keywords	BRUE, ALTE, life threatening, CPR, choke, 00746
Accreditation references	NSQHS Standards (1-8): <ul style="list-style-type: none"> • Standard 1 Clinical Governance, • Standard 5 Comprehensive Care, • Standard 8 Recognising and Responding to Acute Deterioration

Appendix 1: BRUE Definition and Inclusion/Exclusion Factors¹

	Includes	Excludes
Brief	Duration < 1min; typically 20-30s	Duration ≥1 min
Resolved	Patient returned to his or her baseline state of health after the event	At the time of medical evaluation
	Normal vital signs	Fever or recent fever
Unexplained	Normal appearance	Tachypnoea, bradypnea, apnea
		Tachycardia or Bradycardia
		Hypotension, hypertension, or hemodynamic instability
		Mental status changes, somnolence, lethargy
		Hypotonia or hypertonia
		Vomiting
		Bruising, petechiae, or other signs of injury/trauma
		Abnormal weight, growth or head circumference
		Noisy Breathing (stridor, sturgor, wheezing)
		Repeat event(s)
Unexplained	Not explained by an identifiable medical condition	Event consistent with gastroesophageal reflux, swallow dysfunction, nasal congestion etc.
		History or physical examination concerning for child abuse, congenital airway abnormality etc.

Event Characterisation

	Includes	Excludes
Cyanosis or Pallor	Central Cyanosis: blue or purple colouration of face, gums, trunk	Acrocyanosis or perioral cyanosis
	Central Pallor: pale colouration of face or trunk	Rubor
Absent, Decreased, or irregular breathing	Central apnoea	Periodic Breathing of the newborn
	Obstructive apnoea	
	Mixed obstructive apnoea	Breath-holding spells
Marked change in tone (hyper- or hypotonia)	Hypertonia	Hypertonia associated with crying, choking, or gagging due to gastroesophageal reflux or feeding problems
	Hypotonia	Tone changes associated with breath-holding spell Tonic eye deviation or nystagmus Tonic-clonic seizure activity Infantile spasms
Altered responsiveness	Loss of consciousness	Loss of consciousness associated with breath-holding spell
	Mental status change	
	Lethargy	
	Somnolence	
	Postictal Phase	

Appendix 2: History Taking in the Assessment of Potential BRUE₁

Features to be considered

Considerations for possible child abuse:

- Multiple or changing versions of the history/circumstances
- History/circumstances inconsistent with child's developmental stage
- History of unexplained bruising
- Incongruence between caregiver expectations and child's developmental stage, including assigning negative attributes to the child

History of the event

- General description
- Who reported the event?
- Witness of the event? Parent(s), other children, other adults? Reliability of historian(s)?
- State immediately before the event
 - Where did it occur (home/elsewhere, room, crib/floor, etc)?
 - Awake or asleep?
 - Position: supine, prone, upright, sitting, moving?
 - Feeding? Anything in the mouth? Availability of item to choke on? Vomiting or spitting up?
 - Objects nearby that could smother or choke?
- State during the event
 - Choking or gagging noise?
 - Active/moving or quiet/flaccid?
 - Conscious? Able to see you or respond to voice?
 - Muscle tone increased or decreased?
 - Repetitive movements?
 - Appeared distressed or alarmed?
 - Breathing: yes/no, struggling to breathe?
 - Skin color: normal, pale, red, or blue?
 - Bleeding from nose or mouth?
 - Color of lips: normal, pale, or blue?
- End of event
 - Approximate duration of the event?
 - How did it stop: with no intervention, picking up, positioning, rubbing or clapping back, mouth-to-mouth, chest compressions, etc?
 - End abruptly or gradually?
 - Treatment provided by parent/caregiver (eg, glucose-containing drink or food)?
 - 911 called by caregiver?
- State after event
 - Back to normal immediately/gradually/still not there?
 - Before back to normal, was quiet, dazed, fussy, irritable, crying?

Recent history

- Illness in preceding day(s)?
 - If yes, detail signs/symptoms (fussiness, decreased activity, fever, congestion, rhinorrhea, cough, vomiting, diarrhea, decreased intake, poor sleep)
- Injuries, falls, previous unexplained bruising?

Features to be considered - continued

Past medical history

- Pre-/perinatal history
- Gestational age
- Newborn screen normal (for IEMs, congenital heart disease)?
- Previous episodes/BRUE?
- Reflux? If yes, obtain details, including management
- Breathing problems? Noisy ever? Snoring?
- Growth patterns normal?
- Development normal? Assess a few major milestones across categories, any concerns about development or behavior?
- Illnesses, injuries, emergencies?
- Previous hospitalization, surgery?
- Recent immunization?
- Use of over-the-counter medications?

Family history

- Sudden unexplained death (including unexplained car accident or drowning) in first- or second-degree family members before age 35, and particularly as an infant?
- Apparent life-threatening event in sibling?
- Long QT syndrome?
- Arrhythmia?
- Inborn error of metabolism or genetic disease?
- Developmental delay?

Environmental history

- Housing: general, water damage, or mold problems?
- Exposure to tobacco smoke, toxic substances, drugs?

Social history

- Family structure, individuals living in home?
- Housing: general, mold?
- Recent changes, stressors, or strife?
- Exposure to smoke, toxic substances, drugs?
- Recent exposure to infectious illness, particularly upper respiratory illness, paroxysmal cough, pertussis?
- Support system(s)/access to needed resources?
- Current level of concern/anxiety; how family manages adverse situations?
- Potential impact of event/admission on work/family?
- Previous child protective services or law enforcement involvement (eg, domestic violence, animal abuse), alerts/reports for this child or others in the family (when available)?
- Exposure of child to adults with history of mental illness or substance abuse?

Appendix 3: Physical Examination in the Assessment of Potential BRUE1¹

Physical Examination

General appearance

- Craniofacial abnormalities (mandible, maxilla, nasal)
- Age-appropriate responsiveness to environment

Growth variables

- Length, weight, occipitofrontal circumference

Vital signs

- Temperature, pulse, respiratory rate, blood pressure, oxygen saturation

Skin

- Color, perfusion, evidence of injury (eg, bruising or erythema)

Head

- Shape, fontanelles, bruising or other injury

Eyes

- General, extraocular movement, pupillary response
- Conjunctival hemorrhage
- Retinal examination, if indicated by other findings

Ears

- Tympanic membranes

Nose and mouth

- Congestion/coryza
- Blood in nares or oropharynx
- Evidence of trauma or obstruction
- Torn frenulum

Neck

- Mobility

Physical Examination - continued

Chest

- Auscultation, palpation for rib tenderness, crepitus, irregularities

Heart

- Rhythm, rate, auscultation

Abdomen

- Organomegaly, masses, distention
- Tenderness

Genitalia

- Any abnormalities

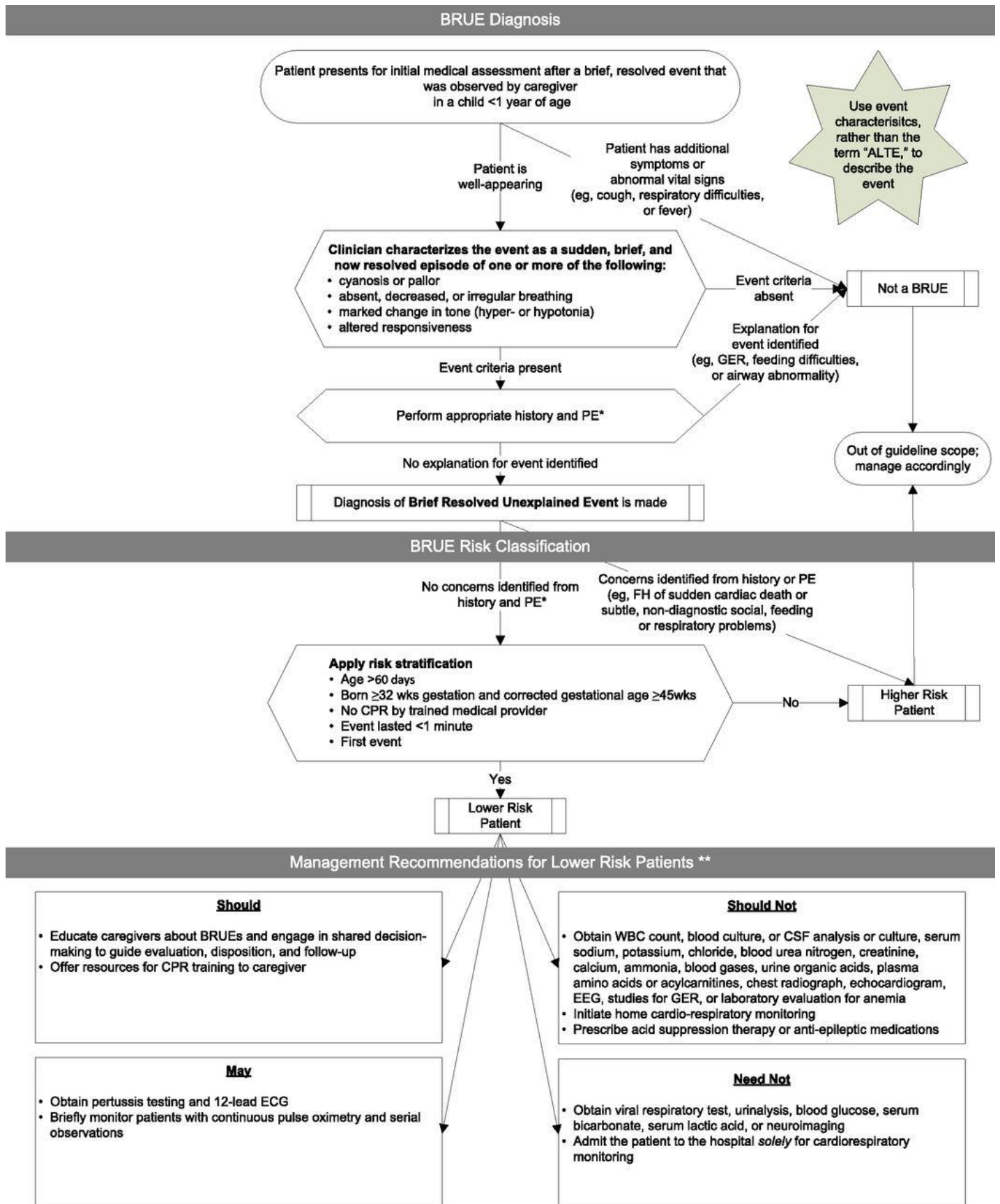
Extremities

- Muscle tone, injuries, limb deformities consistent with fracture

Neurologic

- Alertness, responsiveness
- Response to sound and visual stimuli
- General tone
- Pupillary constriction in response to light
- Presence of symmetrical reflexes
- Symmetry of movement/tone/strength

Appendix 4: BRUE Diagnosis & Risk Stratification Flowchart¹



Appendix 5: Differential Diagnosis of Low- and High-Risk BRUE1

Differential Diagnosis of Low- and High-Risk BRUE

Otolaryngologic

- Maxillary hypoplasia
- Micrognathia
- Macroglossia
- Choanal atresia
- Pyriform aperture stenosis
- Laryngomalacia/anomalies
- Subglottic stenosis
- Tracheomalacia/anomalies
- Adenotonsillar hypertrophy
- OSA
- Vaso-vagal response
- Unintentional suffocation

Gastrointestinal

- GER
- Dysphagia/choking
- Esophageal dysmotility
- Laryngeal chemoreflex
- Bowel obstruction
- Gastroenteritis
- Tracheoesophageal fistulas
- Esophageal foreign body
- Intussusception

Cardiovascular

- Channelopathies (prolonged QT syndromes, Brugada syndrome, short QT syndrome)
- Congenital heart disease
- Vascular ring/sling/compression
- Cardiomyopathy/myocarditis
- Ventricular pre-excitation (Wolff-Parkinson-White syndrome)
- Arrhythmia
- Sepsis

Pulmonary

- Aspiration
- Asthma
- Foreign body
- Congenital airway anomalies/malacia
- Infection Hemorrhage
- Upper and lower respiratory tract infection

Infectious

- Bronchiolitis
- Pneumonia
- Croup
- Upper respiratory infection
- UTI
- Sepsis
- Meningitis
- Gastroenteritis
- Viral syndrome
- Specific organisms (pertussis, RSV, and other respiratory viruses)

Genetic/metabolic

- IEMs (fatty acid oxidations disorders, urea cycle disorders)
- Mitochondrial disorders
- Electrolyte disturbance
- Hypocalcemia
- Hypoglycemia

Child maltreatment

- Abusive head trauma
- Caregiver-fabricated illness (also known as Münchhausen by proxy and medical child abuse) Intentional suffocation
- Poisoning
- Medical neglect

Toxin exposure

- Syncope

Neurologic

- Seizures
- Stroke
- Intracranial mass lesion
- Brain/intracranial structural or vascular abnormality
- Intracranial haemorrhage
- Hydrocephalus
- Neuromuscular disorder
- Congenital central hypoventilation syndrome
- Apnea of prematurity
- Infant botulism
- Demyelinating disorder (transverse myelitis, multiple sclerosis, acute disseminated encephalomyelitis)

- Medication adverse effect
- Substance exposure via human milk
- Environmental exposure
- Vaccine reaction

Miscellaneous

- Acrocyanosis
- Hypothermia
- Breath-holding spell
- Idiopathic