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Epiglottitis management guidelines

Epiglottitis is a cellulitis of supraglottis that can cause a compromise of the airways. An emergency of the airways, especially in children, and precautionary measures should be taken. Epiglottitis is classically described in children aged 2 to 6 years; however, it can occur at any age, including in newborns. In countries that have introduced routine haemophilus influenzae type B (Hib) vaccination, it is now extremely rare in children and may be more common in adults. The most common signs are the rapid onset of high fever, sore throat, inability to control secretions, classic tripod positioning, difficulty breathing, and irritability. Adults may have a more indolent presentation and may not require airway surgery (only about 11% of adults require intubation while most children do). Cooperation between the otolaryngologist, the paediatrician or the emergency department anaesthetist is crucial. No action should be taken that could stimulate a child with suspected epiglottitis, including examination of the oral cavity, starting intravenous lines, blood draws, or even separating a parent. Similar caution is required in acute fulminant epiglottitis in adults. Diagnosis is made for clinical reasons, and laboratory or other interventions should not prevent or delay timely airway control if epiglottitis is suspected. Once the airways have been secured and antibiotics have been launched, the condition usually resolves quickly. Vaccination does not rule out the possibility of epiglottitis or even the possibility of Haemophilus influenzae epiglottitis. Epiglottitis is a cellulite of supraglottis with the potential to cause airway compromise, and should be treated as a surgical emergency until the airways are examined and secured. [1] Duncan NO. Respiratory tract infections. In: Cummings CW. Otolaryngology: head and neck surgery, 4th ed. Philadelphia, PA: Mosby; 2005. Relevant diagnostic criteria include the patient's classic tripod position, drool, high fever, and a toxic appearance. Bacterial epiglottis infection in young children caused by Haemophilus influenzae (Hib), it is rare when hib vaccine coverage is high. It can be caused by other bacteria and occur in adults. Clinical Characteristics - Rapid Start (Less than 12-24 Hours) of High Fever.- Typical tripod or sniffing position, preferring to sit, leaning forward with an open mouth, appearing anxious.- Difficulty swallowing, drooling, and respiratory distress.- Stridor may be present opposition to croup, the hoarse voice and cough are usually absent. Allow the child to sit in a comfortable position or on the parent's lap. Do not force them to lie down (may precipitate airway obstruction). Avoid any examination that will disturb the child, including examination of the mouth and throat. Treatment - In the event of impending airway obstruction, emergency intubation or tracheotomy is indicated. Intubation is technically difficult and must be performed under by a doctor familiar with the procedure. Be prepared to perform a tracheotomy if the intubation fails.- In any case: - Insert an IV peripheral line and provide IV hydration. Avoid the GI route (may agitate the child and precipitate respiratory arrest). Children: 50 mg/kg once a dayAdults: 1 g once a dayISTiving treatment is administered for at least 5 days, then, if the clinical condition has improved and oral treatment can be tolerated, switch to: amoxicillin/clavulanic acid (co-amoxiclav) PO to complete a total of 7 to 10 days of treatment. Use formulations in a ratio of 8:1 or 7:1 exclusively. The dose is expressed in amoxicillin: Children 'lt; 40 kg: 50 mg/kg 2 times a dayChildren ≥ 40 kg and adult:Ratio 8:1: 3000 mg per day (2 1500/62.5 mg tablets 3 times a day)Ratio 7:1: 2625 mg per day (1 tablet of 875/125 mg 3 times a day) Department of Anesthesia, National Children's Medical Center, George Washington University, Washington D.C., UsaFind articles by Claude AbdallahAuthor information Copyright and License information WarningCopyright: © Saudi Journal of AnaesthesiaThis is an open access article distributed in the words of the Creative Commons Attribution-Noncommercial-Share Alike 3.0 Unported, which allows unrestricted use, distribution and reproduction in any medium, provided the original work is properly cited. Acute epiglottitis is a life-threatening disorder with serious implications for the anaesthetist because of the potential for laryngospasm and irrevocable loss of the airways. Acute epiglottitis can occur at any age. Early diagnosis with prompt and careful intervention of this serious condition is necessary in order to avoid life-threatening complications. Keywords: acute epiglottitis, anesthesia, differential diagnosis, management, trendsThe epiglottitis disorder is a potentially fatal disorder with serious implications for the anaesthetist because of the potential of laryngospasm and irrevocable loss of the airways. There is inflammatory edema of arytenoids, aryepiglottic folds and epiglottis; therefore, supraglottitis can be used instead or preferred to the term acute epiglottitis. Acute epiglottitis can occur at any age. The organism responsible was type B hemophilia (Hib), but infection with b-hemolytic streptococci in Group A became more common after widespread use of influenza hemophilia vaccination. There are differences in trends, occurrences and management of acute epiglottitis between children and adults. There is also more diversity in the cause of epiglottitis in adults. [1] The impact of adults ranged from 0.97 to 3.1 per 100,000, with mortality of about 7.1%. The average annual incidence of acute epiglottitis per 100,000 adults increased from 0.88 (1986-1990) to 2.1 (1991-1995) and 3.1 (1996-2000). [2.3] This increase appears to be unrelated to influenzae type B infection, but linked to various pathogenic bacteria. The number of epiglottic abscess increased simultaneously with an increase in the incidence of acute epiglottitis. In adults, a more diverse microbiological etiology is found with often negative sputum cultures and negative blood cultures at Hib. Some cases of epiglottitis have been attributed to Candida spp. Non-infectious causes of epiglottitis may include trauma from foreign objects, inhalation and chemical burns, or are associated with systemic disease or reactions to chemotherapy. The presence of dysphagia, drool and stridor after thermal or caustic damage should alert the treating physician to the possibility of damage to supraglottic structures with the resulting epiglottitis. Epiglottic damage of this type should be suspected in patients with mental disorders or communication difficulties. In young adults, acute epiglottitis has been described as being caused by inhaling heated objects when they smoke illicit drugs; symptoms, signs, x-ray and laryngoscopic findings are similar to infectious epiglottitis. [3] These adults present many features seen in acute infectious epiglottitis, and should be handled with the same consideration for potential upper airway obstruction. In an eight-year retrospective (1998-2006) on epiglottitis admissions, Shah et al. found that epiglottitis continues to be an important entity, with two particularly vulnerable populations: infants- and the elderly(85 years). On the 18-year-old exam, 34.4% were This category of age seemed to have increased in frequency in representing 26.8% of pediatric patients in 1998 to 41.1% in 2006. [5] A case of epiglottitis with negative cultures has been reported in a neonate within hours of birth. [6] The typical presentation in epiglottitis includes acute occurrence of high fever, severe sore throat and difficulty in swallowing with the sitting up and leaning forward position in order to enhance airflow. There is usually drooling because of difficulty and bread on swallowing. Acute epiglotttitis usually leads to generalized toxemia. The most common differential diagnosis is croup and a foreign body in the airway. A late referral to an acute care setting with its serious consequences may result from difficulty in differentiation between acute epiglottitis and less urgent causes of a sore throat, shortness of breath and dysphagia. Antibiotic therapy is usually initiated without preceding bacterial culture, with the consequence of negative cultures at admission. Viral laryngotracheobronchitis, which results in swelling of the mucosa the subglottic area of the larynx, is the most common etiology of croup. There is no seasonal predilection to epiglottitis, while croup is more prevalent during the wintertime. Croup has a more gradual onset than acute epiglottitis, and is commonly associated year= seemed= to= have= increased= in= frequency= in= representing= 26.8%= of= pediatric= patients= in= 1998= to= 41.1%= in= 2006. [5]= a= case= of= epiglottitis= with= negative= cultures= has= been= reported= in= a= neonate= within= hours= of= birth. 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[7] Other less common differential diagnoses would include bacterial tracheitis, laryngeal foreign body and retropharyngeal abscess. Anteroposterior x-rays of the neck are useful in confirming the diagnosis and excluding the possibility of a foreign body in the airways. In the croup, the supraglottic structures and epiglotic shadow are normal, while there is blurring of the tracheal air shadow and symmetrical narrowing of the subglottic air shadow, which creates the characteristic sign of church steeple on earlier films. In acute epiglottitis, the radiological thumb sign [Figure 1] is indicative of severe inflammation of the epiglottis with the potential for irrevocable loss of the airways. Breathing difficulties and stridor are common signs of epiglottitis in children, but are less common in adults. The most common symptom in adults is odynophagia (100%), followed by dysphagia (85%) and voice change (75%).[8] In adults, stridor is considered a harbinger of upper respiratory tract occlusion. Stridor, tachycardia, tachypnea, rapid onset of symptoms and a sign of the thumb present in 79% of cases on lateral X-rays of the neck are significant predictors of an imminent compromise of the airways with rapid clinical deterioration. [9] Laboratory tests are generally not helpful in making the diagnosis. In the absence of a positive radiological finding, the performance of a flexible fiberoptic laryngoscopy in a controlled clinical setting for a reliable and timely diagnosis may be indicated. Due to the risk of inducing laryngeal spasm and/or total airway obstruction, examination of the pharynx and larynx should only be attempted in an area where adequate equipment and personnel are ready to respond if upper airway obstruction ideally develops in the operating room. Ultrasound has been described as a way to study epiglottis by visualization of the P sign of the alphabet in a longitudinal view through the thyrohyoid membrane [Figure 2]. [10] Patients with signs of upper airway obstruction, consistent with epiglottitis should be treated as a medical and air emergency. In the presence of respiratory distress, diagnostic procedures and x-rays are not indicated, and airway safety should be prioritized. Tracheal intubation of a patient with epiglottitis should be considered a potentially difficult procedure [Figure 3]. It must be done under strictly monitored conditions, i.e. in the operating room, operating room, spontaneous ventilation. The readiness of a team capable of performing an immediate tracheotomy must be checked. The patient must be transferred to the operating room under the supervision of an anaesthetist and experienced surgeon. Induction can be performed with the patient sitting upright. Forcing the child/patient into a supination position can precipitate acute airway obstruction. The induction of anesthesia with the realization of a deep level of anesthesia and maintenance of spontaneous ventilation has been described as the method of choice. The time required to produce deep anesthesia using inhalation induction may be increased secondary to airway obstruction and may require an increase in gas concentration. Capnography with exhaled gas analysis is useful for determining anesthetic depth. Muscle relaxants are avoided and spontaneous ventilation should be maintained. In the case of the diagnosis of epiglottitis, a fibrooptic nasal intubation or rigid bronchoscopy using an endotracheal tube with significantly reduced diameter is preferred. The patient must be transferred under control to an intensive care unit (ICU) after securing the airways. Intravenous sedation should ideally allow spontaneous ventilation. Tracheal extubation should be preceded by a cuff leak test with a deflated cuff and, usually, a second look by direct laryngoscopy with deep sedation or general anesthesia. Complications of acute epiglottitis may include deep neck space infection, recurrent disease and vocal granuloma. [11] Treatment of dexamethasone or budesonide aerosols could be used in an attempt to limit pharyngeal edema and thus reduce obstruction. The use of corticosteroids was associated with shorter intensive care and overall length of stay, with an average overall length of stay of 3.8 days in adults. [8] Acute epiglottitis is a serious condition requiring careful and prompt intervention to avoid life-threatening complications. Source of support: NilConflict of interest: None reported.1. Mathoera RB, Wever PC, van Dorsten FR, Balter SG, from Jager CP. Epiglottitis in the adult patient. Neth J Med. 2008;66:373-7. [PubMed] [Google Scholar] 2. Berger G, Landau T, Berger S, Finkelstein Y, Bernheim J, Ophir D. 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