**EPIGLOTTITIS**

**Diagnosis**

*Septic*
*NO cough*
*Rapid onset*
*Expiratory snore*
*Drooling*

*The diagnosis is clinical. If any doubt about diagnosis, call senior colleague. Do not send child to Radiology for lateral neck Xray*

**Management**

1. Get help (Intensivist/Anaesthetist/ENT)
2. Admit to PICU with medical staff in attendance until airway secure
3. DO NOT attempt to examine throat
4. Maintain child in position of comfort in presence of parent/caregiver
5. Attach SpO$_2$ monitoring. ECG, BP can be done if does not upset child
6. DO NOT place iv or take blood samples
7. Provide O$_2$ in a non distressing manner

**Intubation Technique**

1. Leave child in a position of comfort and allow parents to stay till child asleep
2. Gas induction with sevoflurane in oxygen - induction is slow (10-15 min), do not hurry
3. CPAP, manipulation of mandible to maintain airway
4. ETT normal size for child, a stylet is useful, bubbles in the laryngeal inlet may guide
5. Intubate orally first, then change to nasal airway. Oedema is displaced with the oral intubation, facilitating the nasal intubation
6. Secure ETT, place Ng in stomach, place arm splints
7. Secure iv access, blood for FBC & culture, throat swab, start antibiotics
8. Place on HME +/- oxygen
9. CXR to check ETT position
10. Allow patient to awaken, sedatives e.g. morphine/benzodiazepine may be initially required
11. CPAP/oxygen may be required for post obstruction pulmonary oedema or parenchymal disease

**Antibiotics**

Cefotaxime 50 mg/kg 6 h 4-5 days OR
Ceftriaxone 100 mg/kg (max 2 g) stat then 50 mg/kg at 24 h
Other Measures

Temperature is a guide to extubation. Paracetamol is not routinely used
Fluids  - limit to 2/3 maintenance
        - may need bolus of colloid if septic
        - consider Ng feeding to help settle
Examine ears – otitis media common
Notify Dept of Health

Extubation

1. A leak around the ETT is not a guide to extubation. The airway obstruction is supraglottic, not subglottic.
2. Resolution of fever, child looks less toxic
3. NPO 4 h
4. Approximately 12-24 h, in daylight hours
5. Examination under anaesthesia is not necessary – supraglottic structures are still oedematous
6. May require nebulised adrenaline (0.5 mg/kg) for post-extubation stridor