

# Stridor in children

## Stridor in children

Infants and children presenting with stridor need careful assessment with a full history and examination as appropriate. If, on presentation, a child is cyanosed and severely unwell, the airway must be secured as soon as possible, but a brief history with important pointers can often be obtained from the parents. History In infants in the first year of life, it is important to establish if the stridor is associated with particular activities such as congenital laryngomalacia or subglottic stenosis. If the stridor is exacerbated by feeding, particularly in the first 4 weeks of life, this suggests a vascular ring compressing the oesophagus or tracheo-oesophageal fistula. If the cry is weak or abnormal, this suggests a vocal fold palsy. If the problem only occurs in association with an upper respiratory tract infection and, in particular, is biphasic, this suggests congenital subglottic stenosis. In a young child, inspiratory stridor and drooling suggest acute epiglottitis, whereas biphasic stridor without drooling suggests laryngotracheobronchitis or croup. Examination It is important, when possible, to observe the child carefully at rest. Once a baby starts to cry, it may be impossible to study its resting respiratory pattern for some time. Ask the mother, not a nurse or a colleague, to move a baby or young child into different positions, such as face down and supine, and watch for changes in respiratory pattern and level of distress. Observe any drooling and, with neonates and infants, always try to watch the child being fed, listening to the trachea and chest with a stethoscope if possible. Always examine the whole child, looking for any evidence of congenital abnormalities before attempting any examination of the throat. - and Summary box 52.9 Acute paediatric stridor /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF If a child is stridulous and drooling, do not attempt to lay them down and do not attempt to look inside the mouth. These manoeuvres are potentially life-threatening as the child may aspirate a large quantity of thick saliva contained within the oral cavity. It is particularly important in acute epiglottitis as the aspiration of thick saliva may be associated with further laryngeal spasm and a respiratory arrest. Restlessness, increasing tachycardia and cyanosis are important signs of hypoxia. If the child is not distressed and drooling, and not markedly stridulous, they may be cooperative enough that it is possible to look inside the mouth and check the palate, tongue and

Congenital Laryngomalacia Laryngeal web Subglottic stenosis Acquired Inflammatory  
Angioneurotic oedema Traumatic Impacted foreign body, laryngeal fracture Infective Epiglottitis,  
laryngotracheobronchitis Neurological Vocal fold palsy Neoplasia Benign laryngeal papillomatosis

infants, a transcutaneous oximeter is invaluable. A resuscitation trolley with the necessary equipment for emergency intubation or tracheostomy should be close at hand before commencing examination. Investigation Plain lateral radiographs of the neck and a chest radiograph can be obtained but only if the child's condition permits. If a child is severely stridulous, they should not be sent to a radiography department without access to medical staff or resuscitation equipment. Examination under anaesthesia is essential in all children whose diagnosis remains in doubt. This

requires a high level of anaesthetic and surgical skill, with appropriate selection of rigid laryngoscopes, bronchoscopes and telescopes. Equipment for an urgent tracheostomy should also be readily available at all times. Stridor in children

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