

children or blow-by in younger children to avoid further agitation (see the [Translating Evidence into Practice](#) box, later in chapter). Whether or not there is an artificial airway, the child requires intensive observation by experienced personnel. The epiglottal swelling usually decreases after 24 hours of antibiotic therapy (ceftriaxone sodium or alternate cephalosporin), and the epiglottis is near normal by the third day. Intubated children are generally extubated at this time. The use of corticosteroids for reducing edema may be beneficial during the early treatment phase.

Children with suspected bacterial epiglottitis are given antibiotics intravenously followed by oral administration to complete a 7- to 10-day course. Family contacts with children younger than 4 years old and any contacts younger than 4 years old are treated with rifampin for 4 days ([American Academy of Pediatrics Committee on Infectious Diseases and Pickering, 2012](#)).

## **Nursing Care Management**

Epiglottitis is a serious and frightening disease for the child and family. It is important to act quickly but calmly and to provide support without increasing anxiety. The child is allowed to remain in the position that provides the most comfort and security and the parents are reassured that everything possible is being done to obtain relief for their child.

### **Nursing Alert**

When epiglottitis is suspected, the nurse should not attempt to visualize the epiglottis directly with a tongue depressor or take a throat culture but should refer the child for medical evaluation immediately.

Acute care of the child is the same as that described later for the child with LTB. Continuous monitoring of respiratory status, including pulse oximetry (and blood gases if the patient is intubated), is an important part of nursing observations, and the IV infusion is maintained as described in [Chapter 20](#).

## **Acute Laryngotracheobronchitis**