**Acute epiglottitis**

## *Executive summary*

## Introduction

Bacterial infection of the epiglottis in young children caused by *Haemophilus influenzae* type b (Hib). It is rare when Hib vaccine coverage is high. The most typical patient affected by epiglottitis is now an urban male in his mid-40s.It is a dramatic, potentially lethal condition characterized by an acute rapidly progressive respiratory obstruction. It is an important differential for croup.

## Target users

* Doctors
* Nurses

## Target area of use

* Outpatient department
* Ward

## Key areas of focus / New additions / Changes

This guidelines addresses the management of acute epiglottitis.

## Limitations

We have limited access to HDU / ITU level care and it may be difficult to get the necessary anaesthetic help to treat these patients in time.

## Presenting symptoms and signs

* Rapid (less than 12-24 hours) onset of high fever
* **Drooling**
* Sore throat
* Dyspnoea
* Neck is hyperextending
* Typical “tripod or sniffing” position, preferring to sit, leaning forward with an open mouth, anxious appearing.
* Difficulty swallowing
* Stridor may be present (as opposed to croup, hoarse voice and cough are usually absent). Stridor is a late sign and suggests near-complete airway obstruction.
* Critically ill appearing.
* Rapidly progressive respiratory obstruction with laboured breathing; a brief period of air hunger with restlessness may be followed by rapidly increasing complete airway obstruction. Complete obstruction of the airway and death can ensue.

Allow the patient to sit in a comfortable position. Do not force them to lie down (may precipitate airway obstruction). Death from asphyxia can occur. This might be precipitated by attempts to examine the throat**; avoid using a tongue depressor or any instrument to examine the throat.**

## Management

**Emergency:** ABC

* Give oxygen
* Secure IV access and give IV fluids.

Consider **urgent referral** in order to secure airway via emergency intubation and tracheostomy (intubate under anaesthesia).

Start IV antibiotic therapy:

* IV ceftriaxone (3 minutes) or IV infusion (30 minutes) at 50 mg/kg OD children and 1 g OD for adults for 5 days.
* If clinical condition improves and oral treatment tolerated, switch to oral co-amoxiclav 50 mg/kg TDS or adults (375 mg TDS & amoxicillin 250 mg TDS). Complete 10 days of antibiotics.

**Improvement criteria include:** fever reduction, diminished respiratory distress, improved SpO2, improved appetite and/or activity

PO Paracetamol at 15 mg/kg TDS

## References

Colledge, Nicki R., Brian R. Walker, Stuart Ralston, and Stanley Davidson. 2010. Davidson's principles and practice of medicine. Edinburgh: Churchill Livingstone/Elsevier.

Epiglotitis. Medical guidelines. Medecins Sans Frontieres. Retrieved from <https://medicalguidelines.msf.org/viewport/CG/english/epiglottitis-16689226.html> on 25th February, 2019.

Kliegman, Robert., et al. Nelson Textbook of Pediatrics. Edition 20. Philadelphia, PA: Elsevier, 2016.

<https://www.nice.org.uk/guidance/ng79/documents/consultation-document> on 23/02/19.

Standard Treatment Guidelines, 6th Edition, 2010. ISBN 978-9988-1-2538-7

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