CLINICAL PRESENTATION ;

HISTORY;

The most common presenting symptom is loud, raspy, noisy breathing. The caretaker may interpret this symptom as wheezing or even as a severe upper respiratory tract infection. Depending on the underlying etiology, the presentation may be acute or chronic and may be accompanied by other symptoms. If symptoms are not observed in the office, especially when they are present only at night, having parents make a tape recording, preferably even videotaping, can provide useful information.

A thorough history may provide helpful clues to the underlying etiology of stridor. Particular emphasis should be placed on the following:

* Age of onset, duration, severity, and progression of the stridor
* Precipitating events (eg, crying or feeding)
* Positioning (eg, prone, supine, or sitting)
* Quality and nature of crying
* Presence of aphonia
* Other associated symptoms (eg, paroxysms of cough, aspiration, difficulty in feeding, drooling, or sleep-disordered breathing)

A perinatal history is especially important and should include direct questioning regarding maternal condylomata, type of delivery (including shoulder dystocia), endotracheal intubation use and duration, and presence of congenital anomalies. A surgical history should be obtained; previous surgical treatment, particularly if it includes neck or cardiothoracic procedures, puts the recurrent laryngeal nerve at risk for injury.

A detailed developmental history should be obtained. In addition, a history of color change, cyanosis, respiratory effort, and apnea should be elicited to determine the severity of stridor. A feeding and growth history should be evaluated because significant airway obstruction can lead to caloric waste, resulting in lack of weight gain and growth. Additionally, regurgitation and spitting up could be a sign of gastroesophageal reflux (GER), which can cause laryngeal and tracheal mucosal irritation that could lead to edema and stridor.

Physical Examination

On initial presentation, especially if the symptoms are of acute onset, the child should immediately be assessed for severity of stridor and respiratory compromise. Special attention should be paid to the following:

* Heart and respiratory rates
* Cyanosis
* Use of accessory muscles of respiration
* Nasal flaring
* Level of consciousness
* Responsiveness

If distress is moderate to severe, further physical examination should be deferred until the patient reaches a facility equipped for emergency management of the pediatric airway. Physical examination of a patient with suspected acute epiglottitis is contraindicated. The patient may prefer certain positions that alleviate the stridor.

The following, if present, should be noted:

* Infection in the oral cavity
* Crepitations or masses in the soft tissues of the face, neck, or chest
* Deviation of the trachea

Care must be exercised in examining (and especially in palpating) the oral cavity or pharynx because sudden dislodgement of a foreign body or rupture of an abscess can cause further airway compromise. Drooling from the mouth suggests poor handling of secretions.

It is important to observe the character of the cough, cry, and voice.

The presence of fever and toxicity generally implies serious bacterial infections.

Careful auscultation of the nose, oropharynx, neck, and chest helps to discern the location of the stridor.

In infants, special attention should be paid to craniofacial morphology, patency of the nares, and cutaneous hemangiomas. Growth parameters are helpful, especially in the evaluation of chronic stridor.