



Causes of biphasic stridor

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It may be indicative of serious airway obstruction from severe conditions such as epiglottitis, a foreign body lodged in the airway, or a laryngeal tumor. Stridor should always command attention to establish its cause. Visualization of the airway by medical experts equipped to control the airway by medical retropharyngeal abscess, croup); subglottic stenosis (e.g., following prolonged intubation or congenital); airway edema (e.g., following instrumentation, drug side effect, allergic reaction); laryngospasm (from aspiration, GERD, or complication, drug side effect, allergic reaction); laryngospasm (from aspiration, drug s the trachea; thyroiditis such as Riedel's thyroiditis; vocal cord palsy; tracheomalacia or tracheobronchomalacia (e.g., collapsed trachea). congenital anomalies of the airway are present in 87% of all cases of stridor post extubation (occurring from pressure of the endotracheal tube on the mucosa as a result of endotracheal tube that is too large (e.g. pediatrics), cuff over inflation, and prolonged intubation times.);[2] tumor (e.g., laryngeal papillomatosis, squamous cell carcinoma of larynx, trachea or esophagus); ALL (T-cell ALL can present with mediastinal mass that compresses the trachea and causes inspiratory stridor) Diagnosis Stridor is mainly diagnosed on the basis of history and physical examination, with a view to revealing the underlying problem or condition. Chest and neck x-rays, bronchoscopy, CT-scans, and/or MRIs may reveal structural pathology. Flexible fiberoptic bronchoscopy can also be very helpful, especially in assessing vocal cord function or in looking for signs of compression or infection. Treatments The first issue of clinical concern in the setting of stridor is whether or not tracheostomy is immediately necessary. A reduction in oxygen saturation is considered a late sign of airway obstruction, particularly in a child with healthy lungs and normal gas exchange. Some patients will need immediate tracheal intubation. If intubation can be delayed for a period, a number of other potential options can be considered, depending on the severity of the situation and other clinical details. These include: Expectant management with full monitoring, oxygen by face mask, and positioning the head on the bed for optimum conditions (e.g., 45 - 90 degrees). Use of nebulized racemic adrenaline epinephrine (0.5 to 3 ml of normal saline) in cases where airway edema may be the cause of the stridor. (Nebulized Codeine in a dose not exceeding 3 mg/kg may also be used, but not together with racemic adrenaline [because of the risk of ventricular arrhythmias].) Use of dexamethasone (Decadron) 4-8 mg IV q 8 - 12 h in cases where airway edema may be the cause of the stridor; note that some time (in the range of hours) may be needed for dexamethasone to work fully. Use of inhaled Heliox (70% helium, 30% oxygen); the effect is almost instantaneous. Helium, being a less dense gas than nitrogen, reduces turbulent flow through the airways. In obese patients elevation of the panniculus has shown to relieve symptoms by 80%. References ^ Holinger LD (1980). "Etiology of stridor in the neonate, infant and child". Ann. Otol Rhinol. Laryngol. 89 (5 Pt 1): 397-400. PMID 7436240. ^ Wittekamp, Bastiaan HJ. Clinical review: Post-extubation laryngeal edema and extubation failure in critically ill adult patients. Crit Care. 2009; 13(6): 233. External links Look up stridor in Wiktionary, the free dictionary. Audio Breath Sounds—Multiple case studies with audio files of lung sounds. Stridor at eMedicine Congenital stridor at eMedicine MedlinePlus Encyclopedia: Breathing sounds -abnormal (stridor) Diseases Database (DDB): 27190 Stridor sounds at R.A.L.E. Lung Sounds ClassificationDICD-10: R06.11CD-9-CM: 786.1External resourcesMedlinePlus: 003074Patient UK: Stridor Retrieved from "Turbulent air flow in a partially obstructed upper airway results in a high pitched sound Location of obstruction at or immediately below the glottis results in Inspiratory Stridor (Biphasic Stridor) A child's small airways are impacted most significantly by even relatively small partial obstructions (Poiseuille's Law)Infant: Airway edema of 1 mm reduces a 2 mm radius airway to 1 mmResistance to flow increases by 2-4 fold Airway Radius By Age at Cricoid CartilageAge 0 to 1 year: 3 mmAge 1 to 2 years: 4.5 mm Most common in younger childrenAirway reduction of 50% (see above) See Awake Nasotracheal Intubation Maintain airway and consider differential diagnosis Ready all airway management equipment (RSI, intubation, failed airway) Airway Papilloma Airway Hemangioma Spasmodic Croup Angioneurotic edema Do not distress a child with suspected partial airway obstruction (e.g. croup)Avoid unnecessary procedures (e.g. delay Intravenous Access until stable)Position child as they are most comfortable Dahan, Campbell and Melville (2020) Crit Dec Emerg Med 34(11): 3-10 Images: Related links to external sites (from Bing) Professional Reference articles are designed for health professionals to use. They are written by UK doctors and based on research evidence, UK and European Guidelines. You may find the Children with Breathing Difficulties article more useful, or one of our other health articles. Treatment of almost all medical conditions has been affected by the COVID-19 pandemic. NICE has issued rapid update guidance is changing frequently. Please visit to see if there is temporary guidance is changing frequently. may vary from the information given below. Stridor is a symptom not a diagnosis and it is important to find the underlying cause. Stridor is a loud, harsh, high pitched 'croaking' and progress to high-pitched 'croaking' and progress to high-pitch the airway (usually extrathoracic - that is, in the trachea, larynx or pharynx). Stridor can occur on expiration in severe upper airway obstruction [1]. The detailed epidemiology of stridor depends on the cause, but it is worth noting the following patterns of disease: Stridor is common in younger children, acute stridor often accompanies upper respiratory tract infection. In children, acute stridor usually occurs with congenital conditions. Stridor in adults is much less common. Chronic stridor in adults often indicates serious underlying pathology. The Venturi principle dictates that when a gas moves forward, the lateral pressure drops. The lateral pressure is helping to hold open the airway and, when this pressure falls, the narrowed flexible airway (particularly so in children) collapses to obstruct airflow and generate the noise characteristic of stridor. involve the central nervous, cardiovascular, gastrointestinal and respiratory systems. These may be acute or chronic and the presentation and causes are considered below[2]. Acute stridor in children. Usually at age 6 months to 2 years. A barking, seal-like cough, low fever and worse at night.Inhaled foreign body:Common, especially in children age of 3 years.Preceded by choking or coughing.Tracheitis:Uncommon cause.Usually occurs under the age of 6 years).Or peritonsillar (usually in adolescents). Presents with high fever and difficulty in swallowing. Retropharyngeal abscesses present with swallowing and hyperextension of the neck. Peritonsillar abscess presents with trismus, difficulty with swallowing and hyperextension of the neck. Periton symptoms of an allergic reaction. Usually within 30 minutes of exposure to an allergen. Epiglottitis. Congenital problems: Laryngomalacia: This is the most common cause of infant stridor. The stridor is biphasic and associated with a weak cry. Unilateral vocal cord palsy is most common and can be secondary to birth trauma or intrathoracic surgery. It usually resolves in the first 2 years of life. Subglottic stenosis: This may be congenital with narrowing of the subglottis and cricoid rings. It can be acquired after prolonged intubation. It causes inspiratory stridor but this can be biphasic and misdiagnosed as asthma. Laryngeal disorders: Congenital laryngeal dyskinesia, exercise-induced laryngeal dyskines or papillomas (vertical transmission of human papillomavirus). Tracheomalacia: This is caused either by external compression or, more commonly, by a defective tracheal cartilageIt is the most common cause of expiratory stridor. Bilateral may be asymptomatic. Bilateral may present with approve or cyanosis during feeding. It can be diagnosed by an inability to pass a nasal catheter. Tracheal stenosis is usually caused by tracheal stenosis is usually caused by tracheal stenosis include external compression from aortic arch abnormalities. Causes of stridor in adults[3] These may again be acute or chronic but the likely causes differ in adults. The presentation and causes are considered in the boxes below. Acute stridor in adults. The presentation and causes are considered in the boxes below. Acute stridor in adults. flaring, tachypnoea and progressive dyspnoea with shallow respirations. Surgical emphysema may be identified as subcutaneous crepitation in the neck or upper chest. Anaphylaxis: As with children, this causes stridor with upper airway oedema and laryngospasm. There may be other signs of respiratory stress. There is often nasal congestion and profuse, watery rhinorrhoea. These respiratory effects are typically preceded by other symptoms including fear, weakness, increased sweating, sneezing, urticaria, erythema and angio-oedema. The signs of shock can then follow rapidly. Acute laryngitis: Stridor is caused by severe laryngeal oedema. The signs of shock can then follow rapidly. Acute laryngitis: Stridor is caused by severe laryngeal oedema. The signs of shock can then follow rapidly. 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This occurs after inhalation of smoke or toxic fumes. Laryngeal oedema and bronchospasm develop within 24 hours. Signs and symptoms can include the discovery of singed nasal hairs, burns around the face, coughing, hoarseness, sooty sputum, crackles, rhonchi and wheezes and signs of respiratory distress. Chronic stridor in adultsA careful history gives helpful clues as to the aetiological cause of the stridor. Examination may occasionally help confirm the diagnosis. It is important to consider the age of the patients and whether the stridor is acute or chronic. Children: Age of onset. Duration, progression and severity of stridor. Precipitating factors (feeding, crying). Whether positional (worse right/left, prone/supine). Whether aphonia is present. Other symptoms (cough, aspiration, drooling, choking, cyanosis, sleep). Severity (colour change, respiratory effort, apnoea). Perinatal history. Developmental history. Consider: It may be possible in both and weight gain. Adults: Onset, duration, progression and severity should all be assessed. Past medical history and details of any trauma or surgery. Consider: It may be possible in both adults and children to elicit signs of the level at which airway narrowing is occurring. If the patient is distressed, defer further examination until equipment and facilities are available for emergency airway management in children and signs of toxicity suggesting bacterial infection. Drooling from the mouth. Character of cry, cough and voice. In children, the craniofacial features, nasal patency and any cutaneous haemangiomas. Any positional preference that alleviates stridor. Palpate (very carefully): Crepitations or masses in the neck, face or chest. Deviation of the trachea. Auscultate: Nose, oropharynx, neck and chest (this can help locate the source of the stridor). Diagnosis is made from the list of causes above. It is useful to consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely and important diagnoses according to age: In neonates, consider the likely acc croup, acute epiglottitis, diphtheria, upper airway burns and anaphylaxis. In adults, consider anaphalaxis, thyroid disease, trauma and tumours. However, remember acute epiglottitis, as this occurs in adults and requires prompt and appropriate management. Rarely, psychogenic stridor in young women[4]. There is a clear distinction to be made between acute and chronic stridor. Some causes of stridor are life-threatening and need quick diagnosis and treatment. Mild stridor may require no investigation is dictated by the clinical situation, the degree of distress and the severity of the stridor. The following may be useful:Pulse oximetry.Arterial blood gases.Imaging:AP and lateral X-rays of the neck and chest (can identify particularly epiglottitis).Special view X-rays to demonstrate air trapping).Contrast studies (if compression, tracheo-oesophageal fistula, gastro-oesophageal reflux suspected).CT scanning (for aberrant vessels and mediastinal masses).MRI scanning (particularly for upper airway and vascular abnormalities).Virtual bronchoscopy[5].Other tests and procedures:Pulmonary function tests (differentiating restrictive/obstructive lesions and upper/lower airway obstruction).Laryngoscopy and bronchoscopy (after oxygen saturations are stable and acute epiglottitis excluded). This depends on the cause of the stridor. Management of the particular causes may be very different. However, the following general points can be made: Emergency management is essentially about maintainance of the airway. Ill patients (moderate-to-severe stridor) should be kept nil by mouth. If management of the airway fails, resuscitation procedures should be followed. In the event of cessation of stridor with airway obstruction: Abrupt cessation of stridor may herald complete obstruction from a suspected foreign body, try to clear this with back blows or abdominal thrusts (clearly not appropriate in acute epiglottitis). Give oxygen. If necessary, perform emergency endotracheal intubation, cricothyroidotomy or tracheostomy with mechanical ventilation. Be prepared to suction any aspirated vomit or blood through the endotracheal or tracheostomy with mechanical ventilation. tube.Medication from corticosteroids to antibiotics can be useful.A variety of surgical procedures may be necessary from tracheotomy to removal of obstructing tumours. Aihole JS; Stridor in a child: It's diagnostic challenges. Respir Med Case Rep. 2020 Feb 1329:101011. doi: 10.1016/j.rmcr.2020.101011. eCollection 2020.Spencer S, Yeoh BH, Van Asperen PP, et al; Biphasic stridor in infancy. 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