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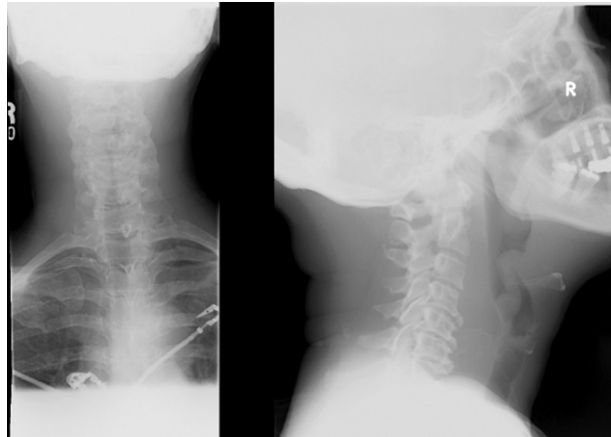


Figure 1. Anterior-posterior and lateral soft tissue radiograph of the neck.

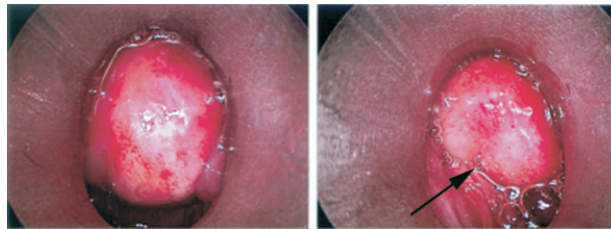


Figure 2. Superior and superior-lateral direct laryngoscopic views of the epiglottis. (Arrow points to glottic opening.) Used with permission of Matthew D. Bitner, MD, Department of Emergency Medicine, Emory University, School of Medicine, Atlanta, GA.

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A 60-year-old woman presented to the emergency department (ED) after being treated earlier in the day in the Express Care area for a 5-day history of ear pain and sore throat. At that time, she was prescribed antibiotics and analgesics for presumed otitis media. Approximately 5 hours later, she re-presented for difficulty swallowing, hoarseness, and shortness of breath. Her vital signs were blood pressure 155/84 mm Hg, pulse 103 beats/min, respirations 20 breaths/min, temperature 37.7°C (orally), and room air oxygen saturation 98%.

The patient was given dexamethasone, albuterol, famotidine, diphenhydramine, clindamycin, and ceftriaxone on arrival for presumed epiglottitis. The radiograph demonstrated epiglottic and aryepiglottic swelling (Figure 1). Subsequent fiberoptic laryngoscopy performed in the ED revealed a large, inflamed epiglottis. The patient subsequently became stridulous and was taken immediately for tracheostomy, where laryngoscopy was repeated and revealed similar findings (Figure 2). She was then transferred to the ICU. After failure to improve by hospital day 4, her antibiotics were changed to levofloxacin and vancomycin, and by hospital day 10 she was discharged, with close otolaryngology follow-up.

For the diagnosis and teaching points, see page 563.

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DIAGNOSIS:

Adult epiglottitis. Adult epiglottitis is an increasingly common phenomenon.¹ However, the clinical presentation may differ slightly from that of the classic drooling, tripodding child. In one review, Frantz et al² found that sore throat and odynophagia were present in 95% and 94% of cases, respectively. Nakamura et al³ found that sore throat was actually the chief complaint in 75% of cases. Additionally, both Frantz et al² and Katori and Tsukuda⁴ found that the presence of stridor significantly increased the relative risk of need for an airway intervention.

Microbiologically, although classically epiglottitis is associated with *Haemophilus influenzae*, the advent of an effective vaccine has caused a decrease in *H influenzae*-associated epiglottitis. In adults, although antibiotic therapy must be directed toward coverage for *H influenzae*, it must also adequately cover *Staphylococcus aureus*, *Streptococcus pneumoniae*, and *Streptococcus pyogenes*.

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