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A Case of Epiglottitis in an Unvaccinated Child

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Abstract

An unvaccinated 4-year-old boy presented with acute epiglottitis due to *Haemophilus influenzae* type b. The case highlights the typical presentation of this disease and the precautions taken to avoid acute and complete airway obstruction.

Case Presentation

The call came after midnight from the mother of a 4-year-old boy, a patient in another practice with which our practice shared call coverage. He was sick with a sore throat and fever, but what concerned his mother was the grunting sound he made with each expiration, which she felt was atypical. Although I had not dealt with her before, this mother seemed clear-headed in her observations, and as I roused myself from sleep, I agreed that this might be more than a typical sore throat that could wait until the morning. Although I had never seen a case of epiglottitis, the potential seriousness of this disease had been emphasized throughout my medical training, and I asked her to take him to the emergency room of our local community hospital, where I would meet them.

I was waiting there when they arrived and immediately ushered them into an exam room. He had a temperature of 38.2° C and a normal pulse oximeter reading. He was indeed grunting with each expiration, but he did not seem to be short of breath. I did not attempt to look at his throat, lest that might gag him and trigger an acute obstruction of his airway, but proceeded directly to a soft-tissue lateral X-ray of his neck. The X-ray showed a thumb-like swelling of the epiglottis, confirming my suspicion. I consulted the ENT doctor on call, who came to the hospital and concurred with my diagnosis. We proceeded to the operating room to secure his airway, having a tracheostomy setup open and ready. Before passing the endotracheal tube, the anesthesiologist allowed us both to peer down the laryngoscope for a quick look at his red, swollen epiglottis. With his airway now secured, we transferred him to a nearby hospital with a pediatric intensive care unit. His cultures grew *Haemophilus influenzae* type b, and he quickly responded to intravenous antibiotics and was discharged home on oral therapy.

This case occurred shortly after Hib vaccines were added to the childhood immunization schedule, and he had not yet received any primary or catch-up doses.

Discussion

Most cases of epiglottitis are due to a bacterial infection causing cellulitis of the epiglottis. The consequent swelling can compromise the airway, and complete obstruction can happen

suddenly and lead to cardiopulmonary arrest and death. Since the introduction of vaccines against Hib in 1988, the incidence of epiglottitis has dropped dramatically to as low as 2 cases per million children among highly vaccinated populations. Before Hib vaccines, Hib was also the most common cause of bacterial meningitis in children in the United States. Since the incidence of invasive Hib infections has fallen by 99%, the USA Public Health Service has targeted Hib disease in children younger than five for elimination [1]. With the rise of "vaccine skepticism" resulting in declining rates of childhood immunizations, one wonders if diseases due to Hib will join measles as another recrudescence of infections we were hoping to eliminate.

Hib has since become a much less frequent cause of childhood epiglottitis, and the age range has changed to older children and adults. Other causative organisms can include *Staphylococcus aureus* (including methicillin-resistant strains), *Streptococcus pneumoniae*, as well as pyogenes and other beta-hemolytic strains, *Neisseria meningitidis*, and *Pasteurella multocida* [2].

Conflict of Interest

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. Informed consent was obtained for this publication.

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