

Anesthesiology
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Epiglottitis in Young Infants

To the Editor:—I would like to endorse the observations of Blackstock *et al.*¹ that "acute epiglottitis may be more difficult to diagnose in the very young infant." In our own study² (which was an update on Benjamin and O'Reilly's study³ quoted by Blackstock), the average patient age was 2.6 yr of age (SD 1.3), with the youngest being 7 months of age. Of greater importance was that, in our study, the five deaths occurred in children ages 14 months to 31 months. The reasons for the deaths are multifactorial and, indeed, conjectural, but would include, in my opinion, lack of experience in assessing airway obstruction in young infants, the small airway itself, and, perhaps, reluctance on the part of the attending physician to make the diagnosis of epiglottitis in this age group. It is for this final reason that Blackstock *et al.*'s article has importance.

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In Reply:—We have reviewed the results of the last 71 cases of acute epiglottitis admitted to the intensive care unit of the British Columbia Children's Hospital (1984–1987), and find no deaths in children less than 2 yr of age. The mean age of all patients was 3 yr 4 months; four (5.6%) were 0–12 months of age, and 21 (29.6%) were 0–24 months of age. The only death occurred in a child 5 years 4 months of age who presented at the emergency department of another hospital and was discharged on two occasions, only to return and suffer cardiorespiratory arrest with resulting brain damage. However, we have a very effective transport team, and send either an anesthesiologist or an intensive care physician to manage the airway in patients with suspected acute epiglottitis prior to transport to the intensive care unit. This may have prevented the death of at least two young infants.

In addition to the factors mentioned by Dr. Baines as the cause of death, we have noted a reluctance on the part of attending physicians to undertake tracheal intubation, fearing that they would cause cardiorespiratory

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REFERENCES

1. Blackstock D, Adderley RJ, Steward DJ: Epiglottitis in young infants. *ANESTHESIOLOGY* 67:97–100, 1987
2. Baines DB, Wark H, Overton JH: Acute epiglottitis in children. *Anaesth Intensive Care* 13:25–28, 1984
3. Benjamin B, O'Reilly B: Acute epiglottitis in infants and children. *Ann Otol Rhinol Laryngol* 85:565–572, 1976

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arrest if they actively interfered with the airway. We are, however, not aware of any deaths following oxygenation with a bag and mask and positive pressure ventilation.

Our experience suggests that tracheal intubation following administration of 100% oxygen with a bag and mask and positive pressure ventilation, or following administration of a general anesthetic with oxygen and halothane, is safe. Conservative management or a delay in tracheal intubation may be fatal, especially in younger infants.

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