

Medical Image of the Week: Acute Epiglottitis

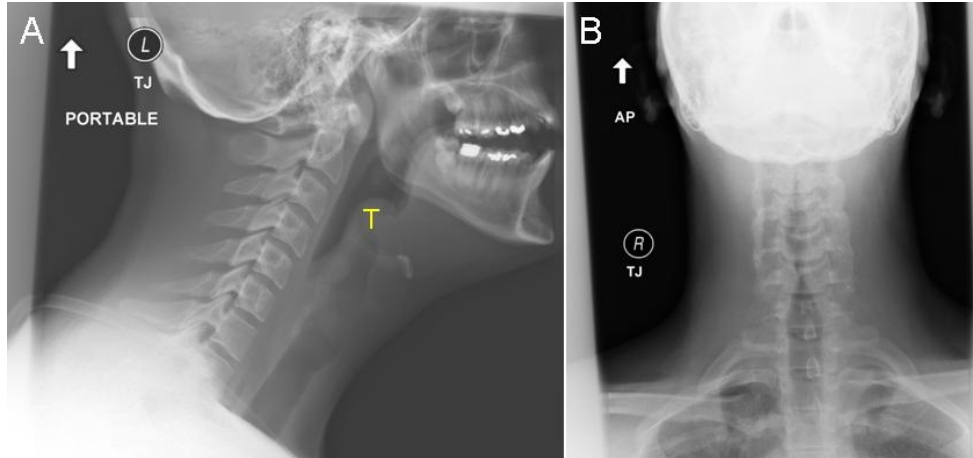


Figure 1. Lateral (Panel A) and AP (Panel B) views of the neck demonstrate a patent airway, but epiglottis and its associated folds are quite thickened suggesting the patient has developing epiglottitis. The lateral view demonstrates a 'thumbprint' sign with an enlarged epiglottis (T).

A 24 year old man without a significant past medical history presented with a 3 day history of sore throat, fever and less than 24 hour history of pain with breathing and swallowing secretions. He was intubated using fiberoptic nasopharyngoscopy in the emergency department due to stridor with a 6.0 mm endotracheal tube until successfully extubated five days later. Initially he was treated with broad spectrum antibiotics and methylprednisolone 40 mg intravenously every 12 hours. A CT scan of the neck did not show an epiglottic abscess.

Acute epiglottitis in adults appears to have a rising incidence with an associated mortality of 7% that is related to *Haemophilus influenzae type b*, as well as other miscellaneous pathogens, mechanical injury or smoke inhalation. Risk factors associated with obstruction are drooling, rapid onset of symptoms, evidence of abscess formation and a history of diabetes mellitus. Epiglottic abscess is infrequent sequelae of acute epiglottitis. Use of steroids in severe cases is common, but there is no evidence of benefit.

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Reference

Berger G, Landau T, Berger S, Finkelstein Y, Bernheim J, Ophir D. The rising incidence of adult acute epiglottitis and epiglottic abscess. *Am J Otolaryngol*. 2003; 24(6):374-83. [\[CrossRef\]](#) [\[PubMed\]](#)