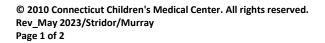
## CT Children's CLASP Guideline Stridor

INTRODUCTION				
	such as primary laryngomalacia, tracheomalacia, or swallowing or reflux issues.			
	Strider sounds generally fall into one of soveral patterns:			
	Stridor sounds generally fall into one of several patterns:			
	<ul> <li>High pitched, "squeaky" inspiratory noise – most typical of laryngomalacia</li> </ul>			
	<ul> <li>Low pitched, expiratory noise – most typical of tracheomalacia</li> <li>Low pitched, biphasis rattly poise ("like a washing machine"), most typical of dyophagia with aspiration</li> </ul>			
	<ul> <li>Low pitched, biphasic rattly noise ("like a washing machine") - most typical of dysphagia with aspiration</li> </ul>			
	Symptoms associated with stridor may include:			
	<ul> <li>Increased work of breathing</li> <li>Neck and chest retractions</li> </ul>			
	<ul> <li>Hoarse voice</li> <li>Difficulty coordinating breathing</li> </ul>			
	<ul> <li>Nasal flaring and swallowing</li> </ul>			
	<ul> <li>Poor weight gain</li> <li>Cyanosis</li> </ul>			
	Stridor in an older child, or stridor with sudden onset, can indicate more urgent needs.			
INITIAL	We in Aerodigestive/ENT are happy to evaluate any child with stridor to help determine etiology and			
EVALUATION	management, and our diagnostic laryngoscopy often gives a definitive diagnosis in one visit. Many			
AND	PCPs are comfortable managing some cases without the definitive diagnosis. Here is a guide to help			
MANAGEMENT	decide which patients to refer and when:			
	Expectant management without specialist involvement likely sufficient:			
	• Otherwise healthy, term infant who is just making noise and not struggling to breathe (nasal			
	flaring and retractions) with no intubation history, no hemangiomas, normal voice and cry,			
	and growing and gaining weight well			
	Refer for specialist evaluation if any Red Flags:			
	History suggestive of etiology OTHER than laryngomalacia:			
	<ul> <li>Intubation history at birth (suggests possibility of acquired subglottic stenosis)</li> </ul>			
	<ul> <li>Hoarse voice (suggests possibility of vocal cord lesion)</li> </ul>			
	<ul> <li>Skin hemangiomas (suggests possibility of concomitant airway hemangioma)</li> <li>Sudden an about another the state of the state of</li></ul>			
	<ul> <li>Sudden or abrupt onset without associated illness (suggests possibility of foreign body aspiration or ingestion)</li> </ul>			
	<ul> <li>Sudden or abrupt onset with associated illness (suggests infectious cause like croup; if severe enough for consideration of specialist involvement, then likely is severe enough for</li> </ul>			
	inpatient management)			
	<ul> <li>Recurrent croup (suggests possible baseline narrowing of airway like subglottic stenosis, or</li> </ul>			
	if young baby, growing airway hemangioma; can also represent an asthma variant)			
	<ul> <li>Frequent or prolonged respiratory illnesses, recurrent pneumonia (suggests aspiration)</li> </ul>			
	<ul> <li>Chronic expiratory stridor and/or barky cough (suggests tracheomalacia; refer to</li> </ul>			
	Pulmonology instead of ENT)			
	<ul> <li>History suggestive of disease for which watchful waiting is <i>not</i> appropriate:</li> </ul>			
	<ul> <li>Poor weight gain</li> </ul>			
	<ul> <li>Dysphagia</li> </ul>			
	o Severe GERD			
	<ul> <li>URI intolerance</li> </ul>			
	<ul> <li>Blue spells</li> </ul>			
	<ul> <li>Pectus excavatum</li> </ul>			





WHEN TO REFER	All persistent stridor can be referred for evaluation; we are happy to see and confirm the diagnosis, usually in one visit.			
	Any patient with a "red flag" above SHOULD be referred to Aerodigestive/ENT.			
	Of note, starting in December 2023, referrals to Pulmonology or Aerodigestive/ENT for recurrent croup will be funneled into our new "Croup Clinic" hosted by both specialties.			
	Routine referral	Semi-urgent referral	Urgent referral	
	(within 1 month) to Aerodigestive/ENT:	(call Aerodigestive/ENT to determine if urgent office visit v ED referral is appropriate):	to ED:	
	<ul> <li>Stridor without signs of respiratory distress</li> </ul>	<ul> <li>✓ Increased work of breathing (nasal flaring, retractions)</li> <li>✓ Biphasic stridor</li> <li>✓ Not gaining weight</li> </ul>	<ul> <li>✓ Cyanosis</li> <li>✓ Choking</li> <li>✓ Drop in pulse oximetry below 92%</li> </ul>	
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HOW TO REFER	Referral to Aerodigestive/ENT Department via CT Children's One Call Access Center Phone: 833.733.7669 Fax: 833.226.2329 For more information on how to place referrals to Connecticut Children's, click <u>here.</u>			
	<ul> <li>Information to be included with the referral:</li> <li>Notes from the initial and follow up visits with the PCP</li> <li>Complete growth chart</li> <li>If child is a NICU graduate, notes on history of intubation (tube size, date intubated)</li> <li>Results of any radiology tests</li> </ul>			
WHAT TO EXPECT	barium swallow), possible swa			

