The Not So Simple Sore Throat

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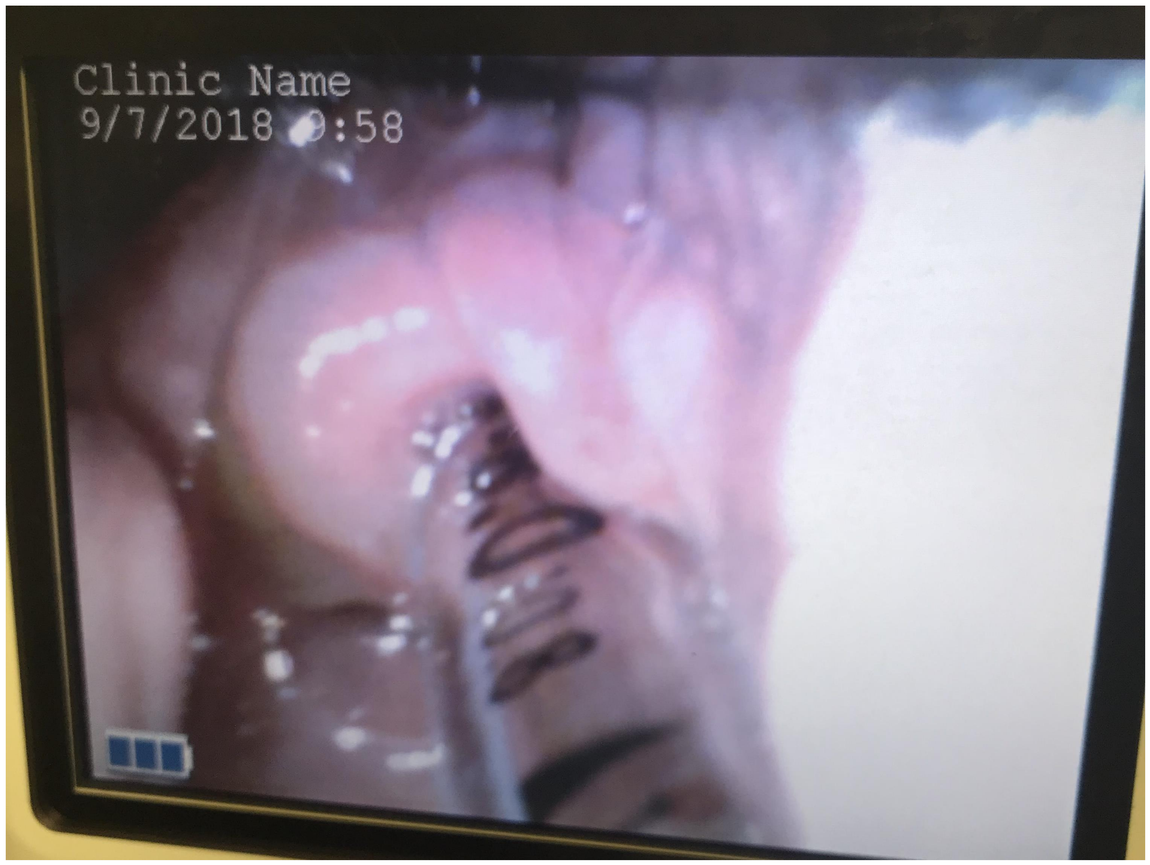
Case Presentation

A 59 year old male with a history of HIV, HTN, and anxiety presented with a sore throat for 1 week. Three days before presentation the patient visited an urgent care center and was given prescriptions for amoxicillin and an oral steroid. He had been taking the prescriptions with no alleviation in symptoms. The patient stated he had an increase in sputum production, a change in his voice and feels anxious when lying flat. He denies any shortness of breath, chest pain, fevers, drooling or coughing. He lives in the United States but recently returned from a trip to Israel. He is fully vaccinated and has an undetectable viral load.

Blood Pressure	164/99
Heart Rate	103
Respirations	17
Pulse Oximetry	98% on room air
Temperature	98.7 (oral) F

Physical examination revealed a non-toxic appearing male speaking in full sentences with no strider or wheezing. His uvula was midline, with no oropharyngeal exudate, erythema or no tonsillar swelling. Laboratory results were significant for a white blood cell count of 20.35 10^3/uL.

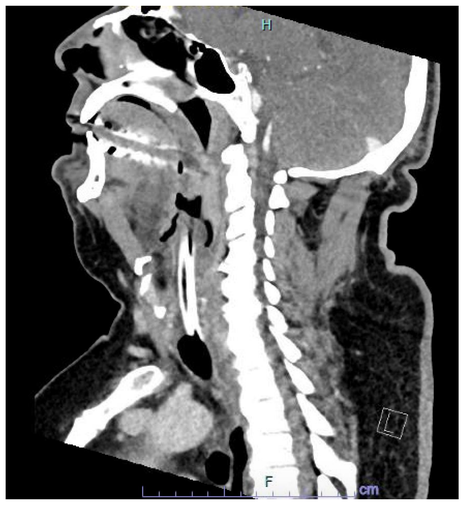
What's the Diagnosis?



Answers & Clinical Course

A computed tomography (CT) scan was ordered due to concern for a deep space infection in the throat as the patient was immunocompromised and had not improved on antibiotic therapy. When the patient was placed supine for the scan, he was unable to tolerate the exam and returned to the ED in significant distress. Repeat vital signs showed an oxygen saturation of approximately 30%. The patient had no stridor or wheezing. Emergent oral tracheal intubation was successful, with video laryngoscopy showing an enlarged epiglottis. A CT of the soft tissue neck revealed low attenuation and edematous appearance of the epiglottis with thickening of the aryepiglottic folds. The patient was treated with broad spectrum intravenous antibiotics pending tracheal cultures, which grew *klebsiella pneumoniae*. He was successfully extubated four days later in the operating room by ENT. He finished seven days of ceftriaxone and was successfully discharged home.

CT Sagittal Soft Tissue Neck



Take Home Points

- The patient with epiglottitis will not always present with stridor in the tripoding position. Dynamic changes and rapid decompensation need to be kept in mind and prepared for.

- As is classically taught, intubation by an anesthesiologist in the operating room with ENT as backup is ideal. Unfortunately, ideal circumstances are not always at our luxury as emergency providers and a degree of adaptation and problem solving is necessary in our field.

- The patient in the case above presented in a true undifferentiated sense, and although hindsight is 20/20, epiglottitis is a rare diagnosis (2 cases per 100,000). Establishing a definitive airway by the most experienced provider in the fewest attempts is paramount in the crashing epiglottitis patient, and a surgical airway should be ready to be performed without any delay.