**What is a “floppy larynx”?** Mr Sunil Sharma explains…

Laryngomalacia (‘immature’ laryngeal cartilage) is the most common congenital laryngeal anomaly and the most common cause of stridor in neonates and infants (accounts for 60-70% of cases); it classically involves intermittent inspiratory stridor that improves in the prone position. Laryngomalacia generally is self-limiting and usually resolves by the age of 18 months, but surgical intervention is warranted in those babies with failure to thrive or blue episodes; it can sometimes be associated with other airway pathology such as subglottic stenosis and tracheomalacia.

Feeding difficulties occur in about half of the babies. It is associated with gastroesophageal reflux which may require treatment. ENT surgeons assess the awake child using flexible fibre optic laryngoscopy. Only the severest 5-20% may need surgical intervention.


Sensible information for parents on [KidsGrowth site](http://www.thinkuknow.com/).

**STRIDOR:**

- Noisy breathing in childhood is commonly reported by parents
- Stridor can be inspiratory (supraglottic or glottis pathology), biphasic (glottis or subglottic) or expiratory (distal tracheal or bronchial)
- Important questions to ask in the history include the onset of stridor, whether it is positional or intermittent, perinal details, history of intubation, quality of cry and voice, drooling, failure to thrive
- The presence of cutaneous haemangiomas and stridor in a child should raise suspicion for subglottic haemangioma; up to 50% of patients with subglottic haemangioma have cutaneous involvement
- Croup is the most common cause of stridor in children, and management is medical with steroids, or nebulised adrenaline in severe cases
- Stenosis refers to pharyngeal obstruction, and is a snoring noise, usually caused by enlarged adenoids and/or tonsils


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**STEP 1: Mild intermittent asthma**

- Prescribe an inhaled short-acting β2 agonist as short term reliever therapy for all patients with symptomatic asthma.
- Use PRN but be aware that good asthma control is associated with little or no need for short-acting β2 agonist.
- Anyone prescribed > 1 short acting bronchodilator inhaler device a month should be identified and have their asthma assessed urgently and measures taken to improve asthma control if this is poor.

**STEP 2: Introduction of regular preventer therapy**

- Inhaled corticosteroids are the recommended preventer drug for adults and children for achieving overall treatment goals. Safe and effective in the under 5s but probably not necessary in non-atomic pre-school children.
- Consider if: using inhaled β2 agonists x3 per week or more; symptomatic x3 per week; waking one night a week; requiring oral corticosteroids in the last 2 years.
- Start children at 100mcg BDP twice a day. Titrate against symptoms to lowest effective dose. ≥ 400mcg total daily dose may be associated with systemic side effects in children. ≥ 800mcg per day BDP should be under a respiratory paediatrician.

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**6th FEBRUARY 2016 WAS “SAFER INTERNET DAY”**

Whipps’ safeguarding team reminded me that I had missed out a couple of good sites from last month’s newsletter topic on E-safety:

- [http://www.childnet.com/](http://www.childnet.com/) for lots of resources for parents, professionals and young people on keeping safe on line
- [http://www.thinkuknow.com/](http://www.thinkuknow.com/) is CEOP’s site for young people and their parents. Formerly the “Child exploitation and on-line protection centre”, officers now work alongside professionals from the wider child protection community and industry. Abuse and cyberbullying can be reported on this site.

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Previous editions are all available at [www.paediatricpearls.co.uk](http://www.paediatricpearls.co.uk)