CROUP – MANAGEMENT IN THE ED

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

Paediatric Improvement Collaborative Guideline

Croup (Laryngotracheobronchitis)

https://www.rch.org.au/clinicalguide/guideline_index/Croup_Laryngotracheobronchitis/

- This guideline is for the management of croup in the Emergency Department (ED). This is to be read in conjunction with the above Paediatric Improvement Collaborative guideline
- Croup refers to a symptom complex of harsh barking cough, which may also have inspiratory stridor and respiratory difficulty. There may be coryzal symptoms. It is usually caused by a virus. Differentiating between spasmodic and viral croup is difficult and often not useful as management is the same
- It is important to consider alternative diagnoses and secondary complications of croup such as bacterial tracheitis, foreign body, anaphylaxis etc.
- Additional information; SCHN Croup Fact Sheet

CHANGE SUMMARY

- Replaces SCH (2015-1023) and CHW (2009-0052) Croup guidelines.
- Updated to link to Paediatric Improvement Collaborative Guideline

READ ACKNOWLEDGEMENT

- All ED clinicians, medical and nursing, must read and acknowledge this document.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
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Team Leader:	Staff Specialist	**Area/Dept**: SCH & CHW Emergency

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Management Flowchart

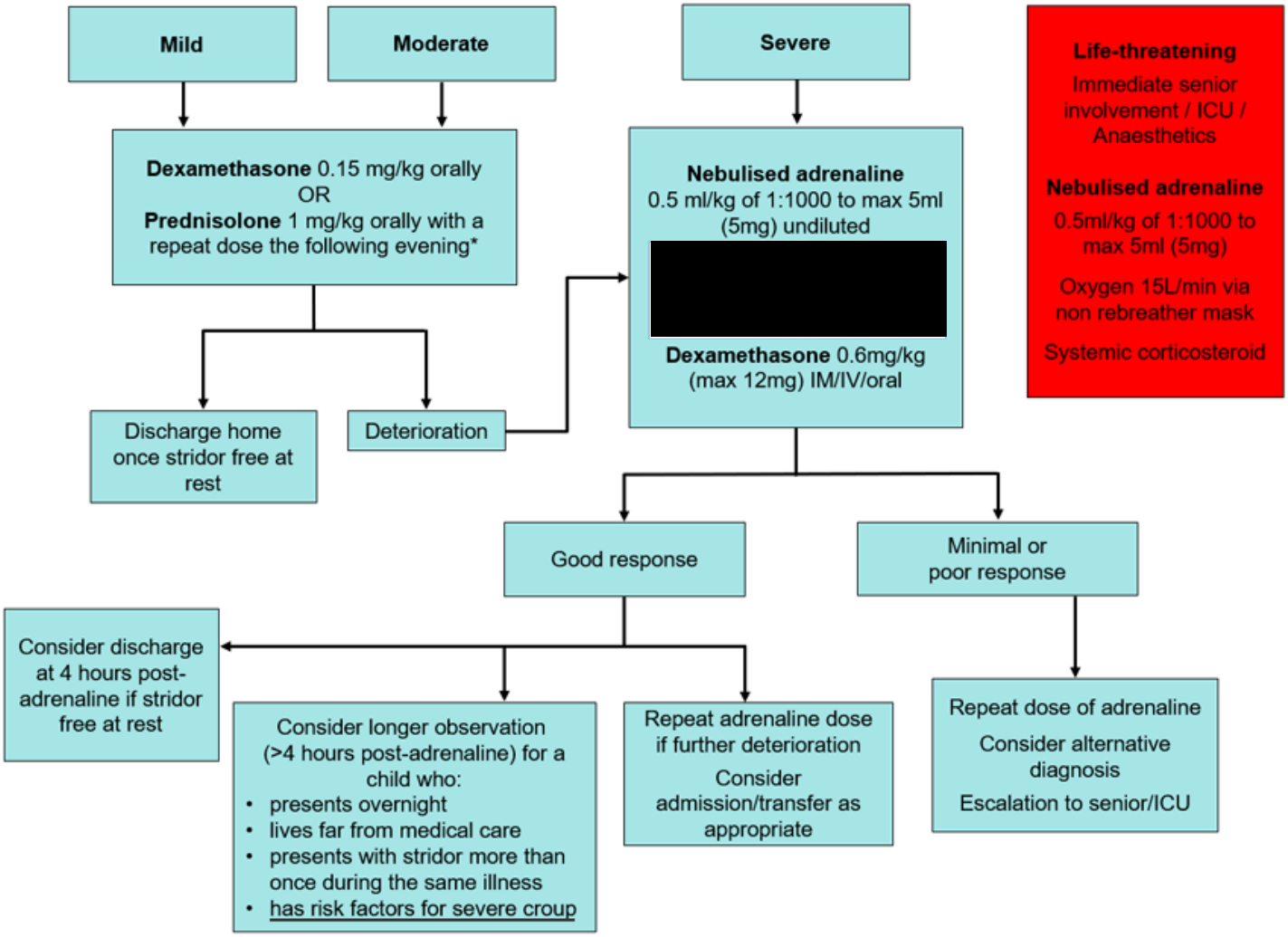

Image adapted from the PIC guideline

Risk factors for severe croup include:

- Pre-existing narrowing of upper airways
- Previous admissions with severe croup
- Young age: uncommon <6 months old, rare <3 months of age. Consider alternative diagnosis and causes of upper airway obstruction

Notes for CHW / SCH Emergency Department

1. If the child has a known or suspected underlying upper airway abnormality, discuss with an ED consultant or fellow. If in doubt, admit. Usually these children would be discussed with the ENT team.
2. At CHW ED, consider Emergency Medical Unit (EMU) admission for a child with mild to moderate simple croup expected to be discharged within 23 hours but not yet able to go home. If longer admission is required, children are generally admitted under the respiratory team. At SCH ED, these children would be admitted under General Paediatrics.
3. Beware of young infants less than 6 months of age. They may have an alternative diagnosis or underlying airway abnormalities. These children are at risk of rapid deterioration and should have an early senior clinician review.
4. Recurrent presentations of croup require consideration of alternative diagnoses and senior clinician review.
5. No evidence supports the use of more than one dose of dexamethasone for children with croup who are suitable for discharge from ED.
6. Please see Meds4Kids or AMH Children's Dosing Companion for dosing guidelines for dexamethasone and prednisolone in the management of croup. Note Dexamethasone suspension is not easily available outside the hospital
7. Contact ED consultant or fellow if 3 or more doses of nebulised adrenaline have been needed. Consultation with PICU may be necessary.
8. Generally, patients can be discharged when well with no stridor at rest. It is reasonable to keep patients presenting overnight until the morning if there are any concerns of diagnosis or safe discharge.

Other resources

- SCHN Factsheet on Croup
- SCHN Factsheet on Passive Smoking

Related Documents

- NSW Health Children and Infants - Acute Management of Croup PD2010_053
- Airway Obstruction - Acute Upper - ED - SCH