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Kawasaki Disease masquerading as retropharyngeal oedema

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SUMMARY

Kawasaki disease (KD) is also known as acute febrile mucocutaneous lymph node syndrome. It can present atypically as retropharyngeal pathology. A previously healthy 6-year-old child presented with fever for 3 days with odynophagia and bilateral cervical lymphadenopathy. Despite the systemic antibiotic, his clinical symptoms did not improve. Fiberoptic endoscopy showed oedematous mucosal tissue over the right posterior naso-oropharyngeal wall. Imaging of the neck showed retropharyngeal oedema with no obvious collection. Over the course of disease, the child developed lips erythema and desquamation. Further blood investigations showed anaemia, leukocytosis, thrombocytosis, raised ESR and hypoalbuminemia. Prompt discussion between otorhinolaryngologist and paediatricians concluded that the child should be treated as incomplete KD, and the child was started on immunoglobulin. Fever subsided and the child improved clinically. Echocardiography showed normal cardiac structures and coronary arteries. No surgical intervention was performed on the child. KD is an acute systemic vasculitis of unknown aetiology, which commonly affects children under 5 years old. Retropharyngeal lesions are formed by local inflammation and oedema or deep neck lymphadenopathy. Positive laboratory criteria include raised CRP and ESR, hypoalbuminemia, anaemia, raised ALT, thrombocytosis, raised WBC and urine WBC of 10/hpf or more. A diagnosis of incomplete KD is made if 3 or more laboratory criteria are fulfilled. The treatment for KD is a single dose of IVIG, and aspirin to prevent cardiac complications. KD can present as retropharyngeal pathology. Early initiation of IVIG is crucial to prevent unnecessary operations and complications of KD.

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A combined tracheal opening and endoscopic procedure for removal of an aspirated foreign body

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SUMMARY

Foreign body (FB) aspiration is a common encountered emergency in the paediatric age group. Aspirated FB can be removed via trans-oral route with the assistance of endoscopic instruments and some may require transtracheal opening. An 8-year-old boy was brought to the Emergency Department for choking a piece of toy. He was turning blue, held his neck and started coughing after the incidence. He regained his breath several seconds later after being given several back blows by his father. On examination, he was not tachypnoeic and no audible stridor with equal air entry on lung auscultation. His oxygen saturation only 92% under room air. Flexible Naso-Pharyngo-Laryngoscopy (FNPLS), chest and neck radiograph performed were unremarkable to suggest a FB. He underwent emergency diagnostic and therapeutic direct laryngoscopy and ventilating bronchoscopy for a suspected FB aspiration. The patient regurgitated clear fluid during laryngoscopy which later proceed with intubation to protect the airway and prevent aspiration. A flexible bronchoscopy performed via ETT to confirmed the present of the FB. The ETT was removed and a ventilating rigid bronchoscopy was performed. The FB was grasped with optical forceps, however the withdrawal was halted at the level of subglottis. Small manipulation of the FB will obstruct airflow through the pinpoint hole of the FB resulting in desaturations. Therefore, a decision was made to remove the FB through trachea opening. Tracheostomy tube was inserted in view of possibility of trachea and subglottic edema post procedure. Foreign body aspiration should be suspected in children with history of choking and physicians must have a low threshold to pursue further diagnostic rigid bronchoscopy. A transtracheal route via a tracheostoma in combination with endoscopic procedure should be considered if the FB is too large to bypass the subglottic.