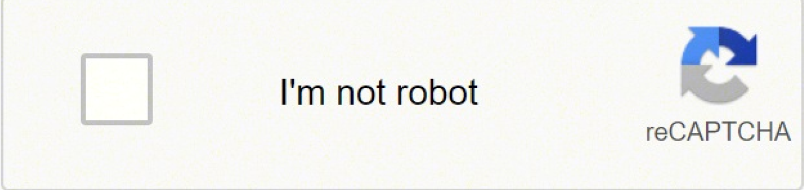
Croup patient pdf



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Croup often causes mild symptoms that get better quickly. Sometimes the symptoms can be more serious and include problems with breathing. It's really important that your child be seen by a doctor if you think they have croup. Children with croup who have difficulty with breathing need immediate admission to hospital.Croup is common in young children, especially between the ages of 6 months and 3 years. Some children have two or more bouts of croup in their childhood. The viral infection can pass from person to person, especially if there is close contact. Croup often occurs in outbreaks or epidemics in the winter.Croup is uncommon after the age of 6 years. Older children can get the same viruses but the breathing tube becomes wider and stronger so the virus doesn't usually cause croup. However, teenagers and, very rarely, adults can get croup.The symptoms of croup include:Cough, which is usually harsh and barking. This croupy cough is due to inflammation and swelling of the vocal cords in the voice box (larynx).Breathing symptoms. The infection causes inflammation on the inside lining of the breathing tube. There may also be a lot of thick mucus. A combination of these can cause narrowing of the breathing tube. The narrowed tube may cause noisy breathing (stridor). Breathing may become difficult if the narrowing becomes worse.Other symptoms that may occur include a runny nose, hoarseness and sore throat. Croup may follow a cold but can also appear without any earlier illness. Other cold or flu-type symptoms may also occur. For example, a high temperature (fever), feeling unwell, being off food and general aches and pains.The symptoms are often worse at night. Typically, during the day a child may have a croupy cough with cold symptoms but not be too unwell. However, at night the cough and breathing symptoms often become worse.Symptoms usually peak after 1-3 days and then improve. A mild but irritating cough may last a further week or so.An infection by a virus that causes croup in a young child may cause a cough or sore throat in an older child or adult but is unlikely to cause the breathing symptoms of croup (described below). However, rarely, symptoms of croup can occur in teenagers or adults. Symptoms are often fairly mild but sometimes become severe. Many children just get a croup cough with some cold symptoms. Any breathing difficulty is often mild. Parents can expect to have one or two disturbed nights nursing a coughing child. Most children with croup remain at home and soon recover.The main concern is if severe narrowing of the breathing tube develops. If this occurs then breathing can become difficult. About 1 in 10 children with croup are admitted to hospital for observation. This is usually if symptoms suggest a narrowing of the breathing tube. Most children admitted to hospital come home within 24 hours as symptoms usually improve quickly. In a small number of cases, a ventilator is needed to help the child to breathe. This is just for a short period whilst the infection and inflammation settle down.Always consult a doctor or nurse if you have any concerns about your child. Most children with croup have mild symptoms and soon get better. However, a small number of children with croup need to be admitted to hospital. In particular, see a doctor quickly if:Breathing symptoms get worse. (Breathing is often noisy with mild croup but it's difficulty in breathing that is worrying.) Signs that breathing is getting worse include:Rapid breathing.Needing more effort to breathe - you may see the chest or neck muscles being pulled in with each breath.The child becomes restless or agitated.The child looks unusually pale.A high temperature (fever) lasts longer than five days.Call for an emergency ambulance if the child is:Blue (cyanosed).Unusually sleepy.Struggling to breathe.Drooling and unable to swallow.Always consult a doctor or nurse if you have any concerns about your child. A doctor will normally advise on what to do, or whether hospital admission is needed. The sort of advice your doctor may give is as follows:Be calm and reassuring. A small child may become distressed with croup. Crying can make things worse. Sit the child upright on your lap if their breathing is noisy or difficult. Let the child find a comfortable position.Lower the high temperature (fever). If a child has a fever their breathing is often faster and they may be more agitated and appear more ill. To lower a fever, give paracetamol liquid (for example, Calpol®) or ibuprofen liquid.Give the child lots of cool drinks (if they are happy to take them).Cool air. Some people find that it is helpful to have a stroll outdoors, carrying the child upright in the cool fresh air.DO NOT give cough medicines which contain ingredients that can make a child drowsy. This will not help a child who may need extra effort to breathe. There is no evidence anyway that cough medicines and decongestants help in croup. Also cough medicines are not suitable for children under the age of 6 years.Antibiotic medicines are not usually prescribed as croup is normally caused by a virus. Antibiotics do not kill viruses.Steam used to be commonly advised as a treatment. It was thought that steam may loosen the mucus and make it easier to breathe. However, there is little evidence that steam does any good. Also, some children have been scalded by steam whilst being treated for croup. Therefore, steam is not recommended.Do not make a child with breathing difficulty lie down or drink fluids if they don't want to, as this can make their breathing worse.A steroid medicine such as dexamethasone is usually prescribed. Steroid medicines help to reduce inflammation. A single dose often eases symptoms within a few hours. Steroid medicines do not shorten the length of the illness but they are likely to reduce the severity of breathing symptoms.Inhaled adrenaline (epinephrine) is sometimes used in hospital to decrease the swelling of the windpipe (trachea) for children with moderate or severe difficulty with breathing. Inhaled adrenaline (epinephrine) often improves croup symptoms 30 minutes after the treatment is given. However, the improvement usually disappears two hours after treatment.

We use cookies to enhance your experience. By continuing to browse this site you agree to our use of cookies. More info. Surgical removal of the coccyx CoccygectomySpecialtysurgical oncology[edit on Wikidata] Coccygectomy is a surgical procedure in which the coccyx or tailbone is removed. It is considered a required treatment for sacrococcygeal teratoma and other germ cell tumors arising from the coccyx. Coccygectomy is the treatment of last resort for coccydynia (coccyx pain) which has failed to respond to nonsurgical treatment. Non surgical treatments include use of seat cushions, external or internal manipulation and massage of the coccyx and the attached muscles, medications given by local injections under fluoroscopic guidance, and medications by mouth.[1] To remove the coccyx, an incision is made from the tip of the coccyx to its joint with the sacrum. The coccyx is cut away from the surrounding tissues, cut off at the joint with the sacrum, and removed. If the tip of the sacrum is rough, it is filed down. The wound is closed in layers.[2][3] Complications and risks As with any operation under anaesthetic, there are risks associated with general anaesthesia itself. An additional possible complication of coccygectomy is infection at the surgical site, due to the site's proximity to the anus, leading to contamination by bacteria from the patient's feces. An analysis of 24 studies of coccygectomy (covering 702 patients)[4] reported that 19 studies (covering 493 patients) reported the post-surgery infection rate, while the other five studies gave incomplete information. Among the patients in the 19 studies with full information, the infection rate was 12%. In most cases the infection was superficial, but 4% of operations caused an infection that required repeat surgery to treat the infection. However, the use of prophylactic antibiotics, preoperative rectal enema, closure of the wound in two layers and use of a topical skin adhesive have been shown to reduce the rate of infection to 0%.[3] In adults who undergo coccygectomy, one rare complication is a subsequent perineal hernia or coccygeal hernia. In these hernias, bowel or other pelvic contents bulge downward and out of the pelvis through a weakened pelvic floor. This complication has not been reported in persons who underwent coccygectomy while a baby or child. A milder version of hernia is when someone just has prolapse (sagging) of the pelvic floor. To repair these hernias, a variety of surgical techniques have been described.[5][6][7] Success rates The coccygectomy operation had a poor reputation in the past, and some doctors still advise that the surgery should be avoided. However current data from clinical trials reports success rates of 50 up to 90%, a percentage that rises to 80-90% in patients that are considered to be 'good candidates' for this kind of surgery. A study that was published in 2001 covering a total of 702 patients found good or excellent results in 83% of cases.[4] See also Rump (croup) Docking (animal) Docking (dog) Coccyx List of surgeries by type References ^ Foye PM (2007). "Reasons to delay or avoid coccygectomy for coccyx pain". Injury. 38 (11): 1328–1329. doi:10.1016/j.injury.2007.06.022. PMID 17884057. ^ An improved technic of coccygectomy. Clinical Orthopedics, 85: 143-145, 1972. Richard C Gardner. ^ a b Prevention of post-coccygectomy infection in a series of 136 coccygectomies. International Orthopaedics, 2011, 35 (6): 877-81. Doursounian L, Maigne JY, Cherrier B, Pacanowski J. ^ a b Coccygektomi kan være en behandlingsmulighed ved kronisk coccygodyni (Coccygectomy may be a treatment option for chronic coccydynia) Ugeskr Læger 2011 Feb 14; 173(7): 495-500. In Danish. Aarby, Nanett Skjellerup (1), Trollegaard, Anton Mitchell (2) and Hellberg, Steen (2) ^ Zook NL, Zook EG (July 1997). "Repair of a long-standing coccygeal hernia and open wound". Plast. Reconstr. Surg. 100 (1): 96–9. doi:10.1097/00006534-199707000-00017. PMID 9207665. ^ Berrevoet F, Pattyn P (June 2005). "Use of bone anchors in perineal hernia repair: a practical note". Langenbecks Arch Surg. 390 (3): 255–8. doi:10.1007/s00423-004-0523-6. PMID 15580523. S2CID 10049165. ^ Miranda EP, Anderson AL, Dosanjh AS, Lee CK (September 2007). "Successful management of recurrent coccygeal hernia with the de-epithelialised rectus abdominis musculocutaneous flap". J Plast Reconstr Aesthet Surg. 62 (1): 98–101. doi:10.1016/j.bjps.2007.08.002. PMID 17889632. External links Coccygectomy Information Retrieved from "

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