

Diagnostic Imaging Pathways - Paediatric, Stridor (Persistent)

Population Covered By The Guidance

This pathway provides guidance on imaging young children with persistent unexplained stridor.

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Quick User Guide

Move the mouse cursor over the PINK text boxes inside the flow chart to bring up a pop up box with salient points.

Clicking on the PINK text box will bring up the full text.

The relative radiation level of each imaging investigation is displayed in the pop up box.

SYMBOL	RRL	EFFECTIVE DOSE RANGE
	None	0
	Minimal	< 1 millisieverts
	Low	1-5 mSv
	Medium	5-10 mSv
	High	>10 mSv

Pathway Diagram

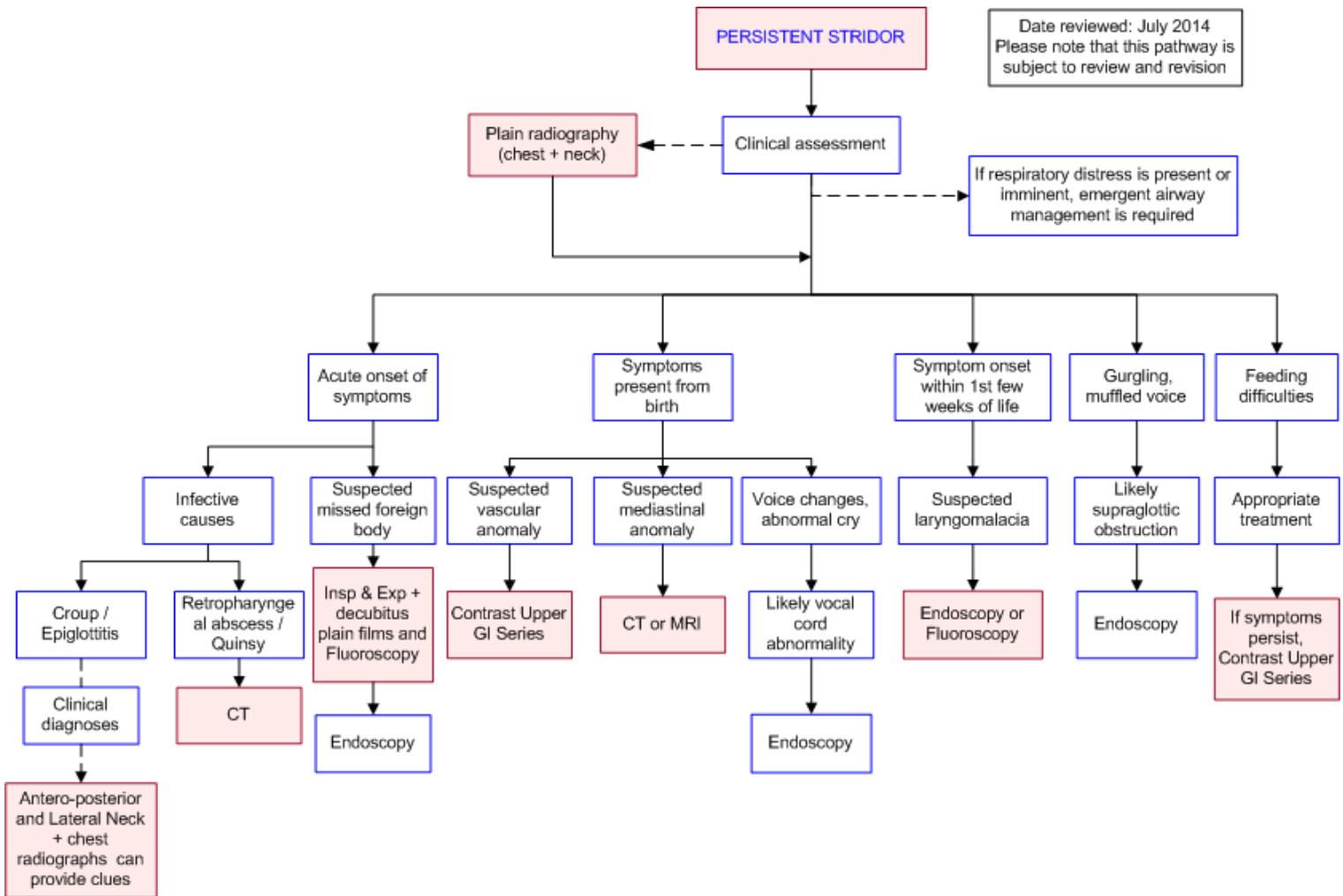


Image Gallery

Note: These images open in a new page

1a



Vascular Anomaly

Image 1a and 1b (Barium Swallow): There is a nasogastric tube in situ. The trachea appears normal. A constant focal narrowing of the posterior oesophagus is seen approximately at the level of the aortic arch with smooth margins (arrow), indicating extrinsic compression of the posterior surface of the oesophagus. This is most suggestive of a vascular anatomic anomaly such as an aberrant retro-oesophageal right subclavian artery causing stridor.

1b



Teaching Points

- Chronic or persistent stridor lasts for more than 3 weeks or recurs on more than 3 occasions
- Initial investigation of persistent stridor is an antero-posterior and lateral views of the chest and neck
- Further investigations are dictated by the most likely diagnosis, based on the age of the child, the onset of symptoms and findings on clinical history and examination

Contrast Upper Gastrointestinal Studies

- Primary indication is to detect the presence of vascular rings and slings causing tracheo-oesophageal compression [9](#)
- Gastroesophageal reflux disease appears to be related to upper respiratory symptoms (e.g. stridor) in the paediatric population, although the strength of the relationship is unclear. Treatment of reflux disease may therefore result in an improvement in respiratory symptoms [10,11](#)
- Various patterns of compression have been documented and may suggest the cause for stridor [2, 12](#)

Cross Sectional Imaging (CT and MRI)

- Cross sectional imaging generally in the form of CT is used for assessing perilaryngeal or mediastinal compressive masses affecting the airway and has largely replaced conventional angiography for investigation of suspected vascular rings [1,12,13](#)
- CT is preferred over MRI because of the long scanning times associated with the latter, requiring young children to be sedated or undergo a general anaesthetic
- Multidetector CT is superior to MRI for assessment of compressive lesions and depicting vascular anatomy. The use of low-dose multidetector CT needs to be studied further, but a case series comparing CT to surgery or endoscopy had an accuracy of 100% [14,15](#)

Fluoroscopy

- Provides a dynamic assessment of the paediatric airway and allows visualisation of partial obstruction, dynamic causes of airway obstruction. Airway fluoroscopy can evaluate

- hemidiaphragm movements and check for localised air trapping [16](#)
- Usually able to demonstrate features of laryngomalacia, including collapse of the laryngeal and supralaryngeal structures during inspiration [16,17](#)
- Significant role in detecting foreign bodies compared to plain films, with a sensitivity of 73%-80% for subglottic, tracheal, bronchial causes of upper airway obstruction. It is less sensitive for diagnosing foreign bodies at supraglottic and glottic sites [16](#)

Persistent Stridor

- Stridor refers to a harsh respiratory noise caused by turbulent air passing through a narrowed airway
- Acute stridor develops over minutes and usually resolves in days but may last up to 2 weeks. Chronic or persistent stridor lasts for more than 3 weeks, or recurs on 3 or more occasions [1,2](#)
- The timing of stridor in relation to the respiratory cycle can indicate the location of the narrowing [3,4](#)
 - Inspiratory stridor usually results from obstruction above the level of the glottis
 - Biphasic stridor suggests obstruction in the area between the glottis and subglottis, or fixed/critical obstruction at any level
 - Expiratory stridor is characteristic of intra-thoracic obstructions
- Causes of stridor include [2](#)
 - Foreign body
 - Laryngomalacia
 - Tracheomalacia
 - Laryngotracheobronchitis
 - Vascular rings and slings
 - Subglottic stenosis
 - Laryngeal or tracheal stenosis
 - Congenital laryngeal web
 - Laryngeal cleft
 - Vocal cord palsy
 - Subglottic haemangioma
 - Retropharyngeal abscess/quinsy
 - Tracheo-oesophageal fistula, cystic hygroma
- The gold standard for diagnosing the cause of stridor is direct laryngoscopy and bronchoscopy [1](#)

Plain Radiography

- The initial investigation for persistent stridor usually involves anteroposterior and lateral views of the neck [4](#)
- Inspiratory and expiratory chest films and decubitus chest films if unable to cooperate with inspiration/expiration are usually done in a PA projection
- High kilovoltage films are required to adequately distinguish between soft tissue and air [3,5](#)
- The sensitivity of plain radiography varies greatly depending on the cause of persistent stridor. Compared to endoscopy, plain radiography has a low sensitivity for functional lesions such as laryngomalacia and tracheomalacia, but this improves for fixed lesions
- A retrospective series found that radiographic findings only correlated with proven endoscopic abnormalities in 18.5% of cases [6](#)
- Inspiratory and expiratory chest films may demonstrate ventilatory differences seen with foreign body aspiration. Sensitivity and specificity for diagnosis of an airway foreign body is 68-73% and

45-67% respectively [4,7,8](#)

References

References are graded from Level I to V according to the Oxford Centre for Evidence-Based Medicine, Levels of Evidence. [Download the document](#)

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