



BOTTOM LINE RECOMMENDATIONS:

Croup

Croup is a common respiratory illness caused by a viral infection of the upper airway.

- » Oral dexamethasone (**1 dose of 0.15 to 0.6 mg/kg, max dose 10 mg**) should be given to **ALL** children with croup.
- » Presence of acute onset barking cough strongly suggests croup.
- » X-rays are rarely necessary to confirm the diagnosis of croup.
- » Because croup symptoms are triggered by a viral infection, antibiotics are **not** effective.

AT INITIAL ASSESSMENT, CHILDREN WITH:

- » **MILD** croup (no inspiratory stridor at rest or indrawing) can be safely discharged home without any further observation.
- » **MODERATE** croup (inspiratory stridor at rest and mild to moderate indrawing) should be observed until both stridor at rest and indrawing resolve (usually a few hours).
- » **SEVERE** croup (stridor, often biphasic, severe chest wall indrawing, and agitation) should be treated with **nebulized epinephrine (5 ml of 1:1,000) and given oral dexamethasone**.

If children are treated with epinephrine they should be observed for a minimum of 2 hours before being discharged from medical care.

CRITERIA FOR SAFE DISCHARGE HOME

- » Absence of inspiratory stridor at rest and respiratory distress (suprasternal, intercostal and chest wall indrawing).

CRITERIA FOR HOSPITAL ADMISSION

- » Persistence of stridor at rest and respiratory distress (defined above) for **4 hours or more after treatment with dexamethasone** (or another corticosteroid) and repeated doses of nebulized epinephrine.

CRITERIA FOR TRANSFER TO CHILDREN'S HOSPITAL INTENSIVE CARE

- » Persistent severe croup (stridor, often biphasic, severe chest wall indrawing, and agitation) despite treatment with two doses of nebulized epinephrine and oral dexamethasone within first two hours of assessment and treatment.

The purpose of this document is to provide health care professionals with key facts and recommendations for the diagnosis and treatment of croup in children. This summary was produced by the croup content advisor for the TREKK Network, Dr. David Johnson of the Alberta Children's Hospital Research Institute, and uses the best available knowledge at the time of publication. However, health care professionals should continue to use their own judgment and take into consideration context, resources and other relevant factors.

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This summary is based on:

1) Alberta Medical Association. *Diagnosis and Management of Croup, Summary of the Alberta Clinical Practice Guideline*, Update 2014. (Accessed online December 1 2016: <http://www.topalbertadoctors.org/cpgs/?sid=1>).

2) Bjornson et al. *The Cochrane Library and the Treatment of Croup in Children: An Overview of Reviews*. Evidence-based Child Health 5: 1555-1565 (2012).

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