

CLINICAL PERSPECTIVES OF INFANTILE WHEEZE

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Infantile wheeze includes recurrent wheeze (two or more episodes of wheezing among the infants) and persistent wheeze (when it persists for more than one month). Multiple factors play roles behind infantile wheeze and include anatomical, genetic, environmental and immunological factors, interacting with each other and affect the airway patency. Resistance to airflow through the airway is inversely related to the radius of the tube to the power of 4 (Poiseuille's law) which means a small change in airway radius results in a large change in airflow resistance. The underlying clinical conditions behind infantile wheeze are bronchiolitis, asthma, GERD, foreign body aspiration, pulmonary TB, airway malformation, congenital heart diseases, cystic fibrosis, bronchopulmonary dysplasia, iron deficiency anemia, post-infectious bronchiolitis obliterans (PIBO), inborn errors of metabolism, cow's milk protein allergy etc. Clinical evaluation includes history of onset of wheeze, bronchiolitis, consanguinity of marriage between parents, prematurity & LBW, vomiting during or after feeding, foreign body aspiration, chronic cough & oily stool, and failing to thrive, anemia, wheeze and murmur on physical examination. Investigations, are centered on CBC, PBF, x-ray chest, contrast x-ray of esophagus with T-position, fluoroscopy, HRCT of chest, gastric lavage for AFB, Gene X-pert, echocardiography, sweat chloride assay, fiberoptic bronchoscopy etc. Management, based on the underlying causes, responsible. It is important to be aware of different phenotypes of infantile wheeze, to diagnose correctly and offer the appropriate treatment to mitigate the sufferings of the children

Keywords: Infantile wheeze, Airway obstruction, Differential diagnosis

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