

Case Report

Racing against Time : Huge Multiple Mass on the Neck

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Abstract

Defining, describing and identifying 'difficult' airways are difficult tasks. The majority of difficult patients that anesthesiologists encounter look 'more-or-less' normal. Anesthesiologists must be prepared to adapt their technique if difficulty occurs. There can be no doubt that the advent of the laryngeal mask airway (LMA) has decreased the frequency of difficulty with the airway. Flexible fiberoptic intubation is a tremendously useful technique, which every anesthesiologist should attempt to master. The advantage of vision, the pre-eminent sense, needs no explanation.

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Introduction

Successful management of difficult airway is based on proper assessment, planning, use of appropriate technique and management of complications. Difficult Airway, not being a single entity, can present in various ways in terms of airway management. Consequently, airway can be managed under airway anesthesia, sedation, general anesthesia (GA) with spontaneous ventilation or with muscle relaxants. The choice depends largely on the anticipated ability to ventilate with face mask and risk of aspiration. Presence of large lesion in the submandibular region or neck can further complicate airway management.

Case Report

60 year old male patient with no co morbid conditions presented with a huge neck swelling which was insidious in onset and progressively increased to present size over 1 year. There were additional multiple small swellings around the main swelling. He had repeated episodes of oral bleeding. There was no dyspnea, dysphagia or symptoms

of airway obstruction. He was an occasional smoker and alcoholic.

Airway Examination

There was a fungating multilobar mass occupying the whole of anterior portion of the neck extending into submandibular region. Mouth opening was adequate with reduced neck extension of less than 80° and flexion less than 25°. Thyromental distance was not appreciable. Temporomandibular joint was normal.

Premedication

- Inj Glycopyrolate 0.2 mg IM was given 45 minutes before the procedure.

Plan

- A. Fiberoptic guided nasotracheal intubation under GA with relaxant with succinylcholine.
- B. Fastrach for back up ventilation
- C. Tracheostomy as a rescue technique



Procedure

In the operating room, after establishing IV access and baseline monitoring, SpO₂, NIBP and ECG, patient was pre-oxygenated for 3min with circle system and O₂ flow of 10L/min.

Induction was done with titrated dose of Propofol. Patient was paralyzed with succinylcholine. Mask holding was difficult and required two hand technique with assisted ventilation. A check laryngoscopy with McCoy's blade revealed a Cormack Lehane grade 4. After a brief period of mask ventilation with 100% of O₂, FOB, loaded with 7.5mm fastrach tube, was introduced nasally through right nostril and the vocal cords were visualized but could not succeed in intubation. Meanwhile, there was a gradual desaturation to 88%. Immediately intubating LMA (ILMA) was inserted and ventilation continued with 100% O₂ using circle system. After the return of saturation to 100%, the fiberoptic was re-introduced by the nasal route. On visualization of LMA cuff in the oral cavity, the tip of the fiberoptic was positioned posterior to it. Then the cuff was deflated, ILMA slightly withdrawn and the scope advanced until the vocal cords were visualized. Fastrach tube was inserted after visualizing tracheal rings and carina and FOB was removed. Capnography and bilateral equal air entry was confirmed and tube was fixed. The intraoperative period was uneventful. Patient was electively ventilated for 24 hours and extubated uneventfully on the 3rd postoperative day, over airway exchange catheter. Airway catheter was removed after one hour and patient was comfortable and was maintained on face mask. He was shifted to the ward after observation for 24 hours.



Discussion

Managing a difficult airway is a challenge to the anesthesiologist. In this patient, difficulty was anticipated for mask ventilation, intubation and rescue procedures. Succinylcholine was chosen as the drug of choice for relaxation because of its short duration with excellent relaxation and also because mask ventilation was anticipated to be possible, though difficult. Check laryngoscopy helped to identify the extent of difficulty in intubation. Hence, according to plan an intubation fiberoptic was used to attempt nasotracheal intubation which we did not succeed in the first attempt. ILMA was immediately employed to provide ventilation which was difficult with face mask and secondary as a conduit for intubation. Second attempt of fiber optic guided nasotracheal intubation was performed after satisfactorily ventilation with ILMA and changing to fastrach tube. Deflation of the cuff and slight withdrawal helped to visualize the vocal cords when tip of nasally passed fiberoptic was maneuvered behind ILMA. This patient management underlies the importance of (a) fiberoptic guided techniques in difficult intubation (b) SAD in this case.



ILMA, to provide rescue ventilation(c)need for combination of more than one technique to achieve airway.

Conclusion

Difficult airway is not uncommon and can present in

different ways. With proper planning, equipment and appropriate skills, airway can be safely managed. Sometimes, a combination techniques and devices are required..

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