



Difficult Airway Control in a Neonatal Patient with Oropharynx Mass

Ahmet Selim Ozkan¹, Muharrem Ucar¹, Mehmet Ali Erdogan¹, Cemal Firat², Aytac Yucel¹, Mahmut Durmus¹

¹ Anesthesiology and Reanimation Department, Inonu University, Malatya, Turkey

² Plastic, Reconstructive and Aesthetics Surgery Department, Inonu University, Malatya, Turkey

Abstract

Tracheal intubation using direct laryngoscopy has become an essential part in the anesthesia management of the surgical patient. Big oropharynx mass can cause serious problems depending on their locations. Mass lesions of oropharynx may lead to difficult intubation. In this letter, we present a successful application of airway management with general anesthesia in a neonatal patient with big oropharynx mass.

Keywords: Difficult, airway control, neonatal, oropharyngeal mass

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Corresponding Author: Ahmet Selim Ozkan, Anesthesiology and Reanimation Department, Inonu University, Malatya, Turkey
E-mail: asozkan61@yahoo.com

Dear Editor;

Tracheal intubation using direct laryngoscopy has become an essential part in the anesthesia management of the surgical patient [1]. Big oropharynx mass can cause serious problems depending on their locations [2]. Mass lesions of oropharynx may lead to difficult intubation [3]. Difficult intubation is a common cause of mortality and morbidity related with anesthesia [4]. In this letter, we present a successful application of airway management with general anesthesia in a neonatal patient with big oropharynx mass.

Patient was born by caesarean section in term as 2850 grams from 27-year-old mother with 1 degree relatives by marriage. A 10-day old neonatal patient with inspiratory stridor and dyspnea came to our hospital in support of nasal CPAP with oropharynx mass (Figure 1). Patient was admitted to the plastic surgery department following diagnosis of his oropharynx mass. Big oropharynx mass (9 x 6 x 4.5 cm) which became invasive to maxillary sinus and eye detected by computed tomography. Surgical removal of the mass was planned under general anesthesia. Lung sounds were normal on physical examination, but respiratory distress was present. Baseline monitoring with electrocardiography (ECG), heart rate (HR), pulse oximeter (SpO₂) and non-invasive blood pressure (NIBP) were monitored. Vital signs were measured with HR: 160 beats/min, SpO₂: 97% and NIBP: 60/35 mmHg. Fiber optic bronchoscope, style, flat blade, laryngeal mask, emergency tracheostomy set and small number of endotracheal tubes were prepared for difficult intubation in the operating room. Premedication wasn't given to the patient. 100% O₂ was given for preoxygenation in 5 minutes. Because of difficult intubation, patient was inhaled with 3% sevoflurane gas to protect spontaneous breathing accompanied by conscious sedation and after 1 minute, laryngoscopy was performed with number 1 flat blade. Patient was evaluated according to the classification of Cormack-Lehane Grade 3. After laryngoscope, the style was passed from the vocal cords. Patient was intubated orotracheal with inner diameter of number 2.5 spiral endotracheal tube, sliding out of style. Place of tube was confirmed with fiber optic bronchoscope and auscultation of lungs. Surgery has begun. Anesthesia was maintained with 50% O₂/50% N₂O and 2% sevoflurane. In operation any complication was seemed in terms of airway control. Mass was resected to include zygomatic bone and eye (Figure 2). Patient was admitted to neonatal ICU in intubated. The pathology of mass was detected grade immature teratom. 1-month later patient had been sent to other hospital for chemotherapy in extubated.



Picture 1. Big Oropharynx mass.



Picture 2. Mass included zygomatic bone and eye.

Consequently, in patients with oropharyngeal mass should be noted that there may be difficult intubation and ventilation. Preparations were needed to be made for difficult intubation. Patient can intubate with spiral endotracheal tube sliding out of style with conscious sedation. We think that patients can be intubated with the help of style in difficult intubation.

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