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Original Research Paper

Anaesthesiology

A LARGE ASYMPTOMATIC EPIGLOTTIC CYST- UN ANTICIPATED DIFFICULT INTUBATION

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ABSTRACT Cysts of the larynx are rare and usually follow a benign course.Epiglottic cysts have a higher prevalence in males(2),and patients who are otherwise asymptomatic (ie, no signs of airway obstruction) are usually followed without any intervention.Asymptomatic or epiglottic cysts with minor symptoms are often detected during intubation and can cause unexpected difficulty with airway management(2).Although in 15% of patients indirect laryngoscopy could not be performed because of excessive gag reflex, indirect laryngoscopy can serve as an effective method to predict difficult intubation.

KEYWORDS : Large epiglottic cyst, difficult endotracheal intubation,Eschmann's endotracheal tube introducer ,Awake fiberoptic intubation,Tracheostomy.

INTRODUCTION:

Epiglottic cysts are benign type of laryngeal lesions and constitute about 5%. Asherson reported an incidence of large epiglottic cysts of 1 in 4200 laryngoscopies[(1)]. Airway management in these patients is extremely challenging due to unanticipated difficult airway in previously undiagnosed or asymptomatic epiglottic cysts detected during intubation. The most common location of ductal cysts is on the true vocal cords, whereas the second most common site is in the vicinity of the epiglottis—on its lingual surface or in the vallecula itself[(3-5)].

Case Study:

A 52yr old male came with a swelling at the level of umbilicus since 2 yrs duration.Patient was posted for laparoscopic hernioplasty under general anesthesia. Patient had no history of hoarseness of voice, stridor,dysphagia and no other comorbidities.

METHODS:

The patient was shifted to the Operation theatre, all the ASA standard monitors were attached, and the baseline vitals were recorded.

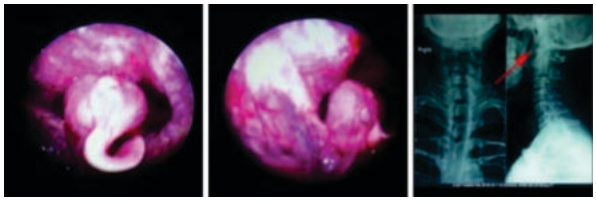
Inj. Glycopyrrolate 0.2mg iv was given. Patient was administered 2mg midazolam and 80mcg fentanyl i.v .Induced with 100mg propofol i.v. Bag and mask ventilation adequate. Inj.Vecuroniumbromide 5mg I.v was given for muscle relaxation. On laryngoscopy , we found a large pink , smooth epiglottic cyst on left side of epiglottis. Mask ventilation was re-initiated with 100% oxygen and laryngoscopy was re-attempted with a video laryngoscope[C-MAC].

The epiglottis along with the cyst could not be lifted out of the way with laryngoscopic blade,which obstructed the view of the vocal cords. Under visualisation with the help of videolaryngoscopy, A Eschmann's endotracheal tube introducer was advanced under epiglottis with the coudie tip pointing anteriorly. As the Eschmann's endotracheal tube introducer was advanced,characteristic 'tactile clicking' was noted due to tip touching the tracheal rings . A 7.5mm endotracheal tube was railroaded over the introducer while maintaining visualisation with the videolaryngoscope and position of the tube was confirmed with capnography.

CONCLUSION:

In conclusion,Awake fiberoptic intubation with airway blocks or tracheostomy with local anesthesia may be method of choice.

Latin phrase 'SEMPER PARATUS' meaning 'ALWAYS READY' should be the motto for an anaesthesiologist as the practice of anesthesiology is studded with surprises.



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