



## AIRWAY MANAGEMENT IN LARGE THYROID MASS

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**ABSTRACT**

Difficulty with intubation will be seen in enlarged thyroid gland producing tracheal deviation, compression, or both. General anaesthesia in such cases are very risky as it may precipitate complete airway collapse and make mask ventilation and tracheal intubation impossible. We used different preparation of lignocaine in various concentrations for anaesthetizing the airway. Inj. Midazolam and fentanyl as sedatives. The combined use of local anaesthesia and mild sedation provided a calm relaxed environment, so smooth intubation was possible without any respiratory compromise. The safe options of airway management left in our case was: awake fiberoptic intubation.

**KEYWORDS :** large airway mass, tracheal deviation, difficult mask ventilation and endotracheal intubation, awake fiberoptic intubation.

**INTRODUCTION:**

Large thyroid gland can lead to compromised airway with difficult tracheal intubation and is potential threat of hypoxia and death. Airway management in these patients are very challenging in view of difficult mask ventilation, difficult laryngoscopy, difficult supraglottic device insertion, and difficult fiber-optic intubation.

**Case Study:**

A 55yrs old female came with a long standing swelling of neck of 15yrs duration off late the swelling on the left side was rapidly growing h/o change in voice and difficulty in swallowing since 1month. Neck range of movements – adequate extension with no flexion.

**METHODS:**

Airway: it is difficult because of distorted anatomy of neck and airway, no option for surgical access. Patient was shifted to OT, all the ASA standard monitors were attached, and the baseline vitals were recorded. Inj. Glycopyrrolate 0.2mg iv was given Xylometazoline was instilled in both the nostrils. Patient's airway was anaesthetized by application of 4ml of 4% lignocaine nebulization, and lignocaine spray 10%, lignocaine viscous 2% gargle and by application of 2%lignocaine jelly in the nostrils. Patient was administered 2mg midazolam and 40mcg fentanyl i.v as anxiolytic and for mild sedation. Bronchoscope was loaded with a 7.0mm armored endotracheal tube, and was inserted through right nostril and advanced towards laryngeal inlet.

**CONCLUSIONS:**

In conclusion, awake fiberoptic intubation with loco- sedative technique is a very viable option in selected group of patients having compromised airway. Preoperative airway assessment is must in all patients in order to know possible difficult airway. Proper planning and discussing the plan with the patient and surgeon are important for safe outcome.

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