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UNANTICIPATED DIFFCULT AIRWAY – AN ENIGMATIC EPIGLOTTIS

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INTRODUCTION

An unexpected difficult airway during the induction of anesthesia is a scenario best avoided. A good pre anesthetic assessment focuses on identifying risk factors to predict a difficult airway like obesity, Mallampatti III or IV, edentulous, limited jaw protrusion, inadequate mouth opening etc. Despite advancements in monitoring , airway devices and robust training, the incidence of such unanticipated airways has not reduced. We present one such case of unanticipated difficult airway in a patient posted for percutaneous nephro-lithotomy.

CASE PRESENTATION

54 year old diabetic male posted for percutaneous nephro- lithotomy. Pre anesthetic airway assessment revealed - Mallampati grade II, adequate mouth opening, normal neck movement, thyromental distance>6.5cm, sternomental distance >12.5cm with a BMI of 26 kg/m2.

ANESTHESIA

Patient was preoxygenated and premedicated. He was induced with Profopol; Mask ventilation was easy, hence atracurium muscle relaxant was given. Direct larygoscopy with 3 size Macintosh blade was done; vocal cords was not visualised. On gentle manipulation, fresh bleed was encountered. A fleshy, irregular mass was noted on the tip of the epiglottis masking the glottic aperture. BURP manoeuvre and external laryngeal manipulation was done, however glottis visualisation was Cormack Lehane grade 3 A Bougie guided intubation was done with size 7.5I.D endotracheal tube. Adrenaline soaked throat pack was kept to arrest bleeding.

INTRA OPERATIVE AND POST OPERATIVE PERIOD

Intra operative period was uneventful.During extubation, throat pack was removed with adequate suctioning Neuromuscular block was reversed and extubated when fully awake.Patient was shifted to post operative recovery room with stable vitals and air saturation maintaining at 99% . ENT opinion sought thereafter.

DISCUSSION

Unanticipated difficult airway can occur despite thorough anesthetic pre-assessment.The anesthetist must be prepared to handle such circumstances. We encountered a patient with epiglottic mass that made it difficult to visualize cords and also presented with active bleeding. Options in such a scenario may include intubation with a gum elastic bougie, fiberoptic bronchoscope or supra glottic devices. In our case supra glottic device was considered unsafe in the setting of active bleeding from the fleshy mass and airway obstruction. Failure of the above steps may necessitate assisted intubation , crico-thyrotomy or tracheostomy as rescue procedure. Control of bleeding during such manoeuvres is also of paramount importance.

CONCLUSION

The discerning anesthetist must anticipate every case as a potential difficult airway and be ready to face any unanticipated surprises. Ease in mask ventilation does not always guarantee an easy airway.

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