**Título:** From Extreme Airway Compression to a Sigh of Relief

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**Resumo:**

Introduction

Flexible fibroscopy has improved the aesthetic approach to a predictable difficult airway on an awake patient under light sedation and local anesthesia. It allows for exploration of the airway without loss of its patency, by preventing muscular atony and preserving protective airway reflexes, while on spontaneous ventilation.

Clinical Case

A 78yo hypertensive woman was evacuated from Guinea-Bissau due a 15-year evolution goitre causing severe dyspnea and preventing dorsal decubitus position for one year now. She presented with odynophagia, dysphagia for solid foods, loud breathing sound, not stridulous, and a voluminous mobile goitre. Thyroid function was normal and on CT scan the goitre measured 10,6 x 7,5 x 6 cm (W x T x AP), had an intrathoracic portion that deviated the trachea to a posterior-right plane and compressed it, causing lumen reduction to a 9 x 4 mm (W x AP) airway chamber. Histology of Nodular Hyperplasia on fine needle aspiration. On airway clinical evaluation, Mallampati 3, Thyromental distance >6cm, normal neck mobility and TMJ. Standing before a predictably difficult airway (for ventilation and intubation), the patient was kept on a semi-recumbent position, awake, under conscious sedation (fentanyl and midazolam), and having anesthetised the airway with lidocaine she was nasally intubated with a flexible fiberscope. A 6.0mm ETT was passed, followed by balanced general anesthesia. Thyroidectomy went without remarks, with the patient being extubated at end of the surgery, still on the OR, fully awake and on spontaneous ventilation.

Discussion

Given the hallmarks of dyspnea, dysphagia, decubitus intolerance, as well as the clinical findings and the CT scan revealing marked tracheal compression, one would risk a Can’t Intubate Can’t Oxygenate situation. As so, the first step on a patient requiring general anesthesia, would possibly be an awake intubation via a flexible fibrescopy, as recommended by ESA, ASA and SPA. Four months after surgery the patient was asymptomatic.

Key points

Such extreme difficult airway cases where the tracheal lumen is minimal are rare. As a first approach, the use of a flexible fibrescope is one of the recommended choices by several anesthesiology societies, being a safer and more successful technique. Patient collaboration is of utmost importance, and without it any attempt is doomed. One must never underrate the importance of a preanesthetic clinical evaluation, comprising anamnesis and medical exams. An airway approach plan, by following an algorithm and anticipating further steps, must be executed. Similarly, an extubation plan must be elaborated, and complications such as stridor by recurrent laryngeal nerve lesion, hemorrhage or hematoma and tracheomalacia can be ruled out, and airway patency ensured.

References

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