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AIRWAY MANAGEMENT IN A HUGE THYROID SWELLING WITH RETROSTERNAL EXTENSION-A CASE REPORT

Anesthesiology

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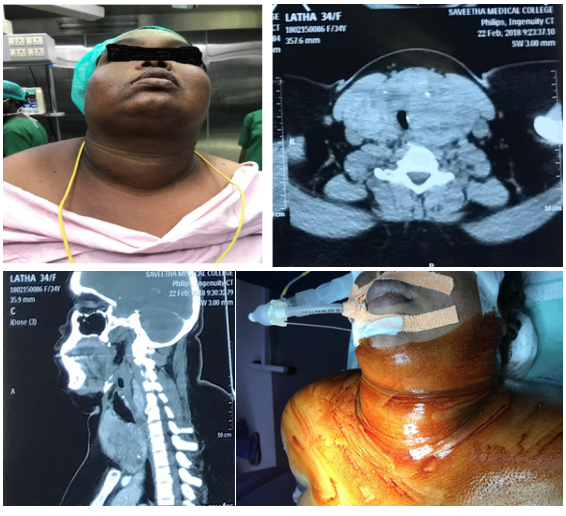
ABSTRACT

A 45 year old female presented with huge thyroid swelling with retrosternal extension and tonsillar extension, along with complaint of dysphagia , facial palsy, TFT normal, vital parameters within normal range .Airway was managed by an awake oral tracheal fibre optic intubation using SAYGO. Scafolding of trachea as visualised in MRI was seen in FOB. Since trachea was involved and para thyroid is also removed she was electively ventilated for 48 hours and was on serial injections of calcium gluconate in post operate period and uneventfully extubated on the POD3. Hence awake FOB guided intubation helps in preventing airway collapse during intubation and helps in establishing secured airway

KEYWORDS

INTRODUCTION:
Large goitre with retrosternal extension can cause a difficult airway. We report a patient with a thyroid swelling with retrosternal extension, tracheal deviation and compression posted for total thyroidectomy.

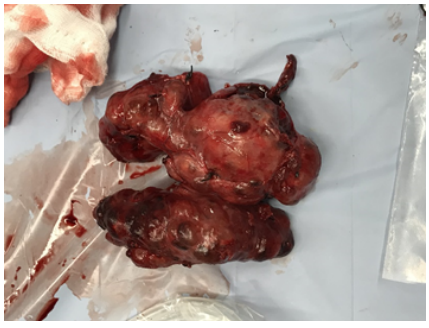
CASE HISTORY:
A 32yr old lady presented with neck swelling since 1 year with pain , dysphagia & dyspnea .There was no change in voice and her vital parameters were normal. TFT were within normal range. Chest x-ray showed deviation of trachea and MRI revealed deviation and scaffolding of the upper part of trachea. IDL revealed mobile vocal cords with congested arytenoids. Mouth opening was normal with restricted neck movements.



MANAGEMENT:
After fasting for 8 hrs prior she was premedicated with I.V glycopyrrolate 0.2mg, ondansetron 4 mg & ranitidine 150mg followed by nebulization with lignocaine 2% and lignocaine viscus gargles. In the O.T she was connected to a multipara monitor displaying NIBP, SPO2, E.C.G, ETCO2 &temperature .Awake FOB was done with SAYGO method till carina was visualized. A 6.5 cuffed flexometallic tube was railroaded. Tube position was confirmed by ETCO2 trace and air entry. I.V propofol 100 mg , fentanyl 100 µg & atracurium 35 mg was given. Anaesthesia was maintained with O2 and N20 (50:50) with isoflurane & incremental doses of atracurium .Total thyroidectomy was uneventful and since the parathyroids were removed, she was electively ventilated for 48 hrs and received IV calcium gluconate . She was extubated on the third post -operative day.

DISCUSSION: The problems associated with huge goitres include difficult intubation , secondary haemorrhage , tracheomalacia, vocal cord palsy & accidental parathyroid excision. Awake fibreoptic intubation is a safe practice in patients with huge goitre.

CONCLUSION: A careful preoperative assessment of the airway and being prepared to deal with post-operative airway complications are must in a case of huge goitre with retrosternal extension.



REFERENCES:

1. Miller RD, Eriksson LI, Fleisher LA. Local anaesthetics and “Awake” techniques of Airway management: Airway management in adult. Miller's Anaesthesia. Churchill livingstone. 2010;7:1573–610.
2. Srivastava D, Dhiraaj S. Airway management of a difficult airway due to prolonged enlarged goiter using loco-sedative technique. Saudi J Anaesth. 2013;7:86–9.
3. Ghai A, Hooda S, Wadherra R, Garg N. Gross tracheal deviation: Airway challenges and concerns — two case reports. Acta Anaesthesiol Belg. 2011;62:203–6.
4. Thallage A, Al-Zahrani T. Anaesthetic management of huge goiter with retrosternal extension. Internet J Anaesthesiol. 2004;10:1.
5. Bajwa SJ, Sehgal V. Anesthesia and thyroid surgery: The never ending challenges. Indian J Endocrinol Metab. 2013;17:228–34.