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General Surgery

A RARE CASE OF 30 OLD FEMALE WITH GOITER INDUCED UPPER AIRWAY OBSTRUCTION

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KEYWORDS :

INTRODUCTION

Multi-nodular goiter usually presents as midline neck swelling and causes tracheal compression only after it attains a large size but when it presents without any visible swelling and causes sudden dyspnea that requires intubation is a challenge to manage.

We recently encountered such a case at Civil Hospital Ahmedabad where with combined team of surgeons, physicians, radiologists and anesthetists we were efficiently able to perform right hemithyroi dectomy in a tracheostomised patient.

CASE SUMMARY

30-year-old female patients presented in emergency with complain of breathlessness and altered sensorium since last 2 days.

Patient was immediately intubated following which she regained consciousness within 15 minutes.

She was subsequently shifted to ICU where trial of extubation was given.

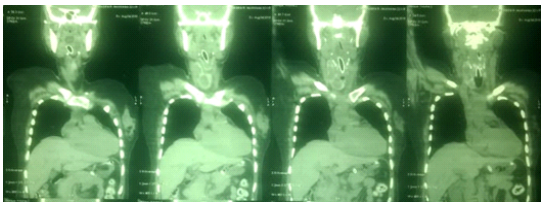
After successful extubation, she again became unconscious and breathless within 15 minutes and again had to be intubated, following which she regained consciousness. Hence following multiple episodes of unconsciousness-intubation-consciousness-extubation, tracheostomy was done 5 days later.

Patient had complains of breathlessness since last 1 year for which she was being managed with bronchodilators by local physician.

Patient had been operated for left hemithyroidectomy 8 years ago for left solitary thyroid nodule.

CT scan of neck and thorax was suggestive to a 32*16*63 mm enlarged hypodense nodular thyroid that caused narrowing of cricoid and post cricoid region for the length of 3-5 cm.

Thyroid function tests were normal.

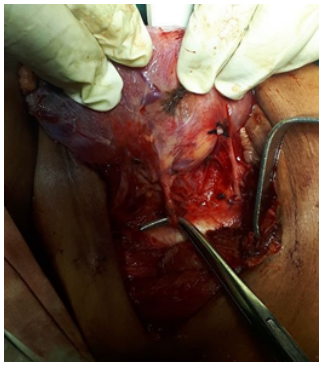


Under general anesthesia, patient was intubated and tracheostomy was removed. Right hemithyroidectomy was performed by a transverse incision 2 cm above the sternal notch. Due to fibrosis from previous surgery and tracheal opening due to tracheostomy, midline could not be identified. Sternocleidomastoid was reflected laterally. Strap muscles were cut. Right external laryngeal nerve was safeguarded and right superior thyroid artery was ligated. Middle thyroid vein was ligated and cut. Right inferior thyroid artery could not be identified. Recurrent laryngeal nerve was safeguarded. Right lobe and pyramidal lobe were hence dissected from trachea. Tracheostomy was done again and skin was then sutured.

Patient was shifted to ICU for mechanical ventilation that was gradually weaned off in 24 hours.

Tracheostomy was also removed on post of day 15. Stitch line and stoma site were both healthy.

Biopsy was suggestive of nodular goiter.



DISCUSSION

Although benign nodular goiter causing airway obstruction is rare, it as important clinical entity that requires emergent management to secure the airway followed by thorough investigation with CT for definitive management.

REFERENCES

1. https://www.ncbi.nlm.nih.gov/pmc/articles/pmc4261473
2. The Eurasian journal of medicine.