Original Research Paper

Volume-9 | Issue-12 | December - 2019 | PRINT ISSN No. 2249 - 555X | DOI : 10.36106/ijar

Anaesthesiology

# MANAGEMENT OF A CASE OF POSTCRICOID GROWTH UNDERGOING ELECTIVE LARYNGECTOMY

| | |
|---|---|
| **Dr.Kala.B** | Department Of Anesthesiology, Sree Balaji Medical College And Hospital, Chennai |
| **Dr.Jaya Hasita*** | Department Of Anesthesiology, Sree Balaji Medical College And Hospital, Chennai*Corresponding author |
| **Dr.Umamageshwaran** | Department Of Anesthesiology, Sree Balaji Medical College And Hospital, Chennai |

**KEYWORDS :**

## Introduction

Oral cancer is sixth most common cancer worldwide.Oral cancer patients have a potentially difficult airway, but if managed properly during the perioperative period, morbidity and mortality can be reduced or avoided

## Case report

65year old male presented with weight loss , dyspnoea, and hoarsness of voice for the past 2 months. Diagnosed to have postcricoid growth on CT. Biopsied to be infiltrating squamous cell carcinoma which was at the level of C3-C4. Patient is a known diabetic for the past 2 years on oral hypoglycaemic agents under control. He is a chronic smoker . Mouth opening permitted 3 fingers and MPC III. There was no restriction of neck movements. Patient was taken up for elective laryngectomy under ASA-III

## Anaesthesia technique

Elective Tracheostomy was done for the patient under local anaethesia in view of complete obstruction seen on CT prior to the surgery. Airway was secured with 7 size I.D flexometallic endotracheal tube. Bilateral air entry was checked and tube was fixed. Patient was then induced with Inj. Profol and Vecuronium was used as a muscle relaxant. Depth of anaesthesia maintained with O2(50%)+N2O(50%)+Isoflurane( 0.5-1%MAC)+ Inj.Vecuronium in titrated doses. Hypotensive anaesthesia was achieved by Inj.Clonidine 1.5mcg/kg initial dose followed by infusion of 0.4mcg/kg/hour. Inj.Morphine was used for analgesia intraoperatively. Procedure duration was 4hours . All the vital parameters were monitored and patient was hemodynamically stable throughout the procedure. Post procedure the Flexometallic tube was removed with partially inflated cuff and tracheostomy tube was kept under vision. Bilateral air entry was checked and tracheostomy tube was secured. Patient was connected to a T-piece and sent to ICU for observation.

## Discussion

Airway management is the main concern in our case. It has been found that tracheostomy is safe as an original procedure for airway management and was done under local anaesthesia without any sedation. In our case an awake fiberoptic guided nasal intubation was not tried as the mass was visualised to be blocking cricoid region on CT at the level of C3-C4. In view of bleeding from the mass risk of aspiration was also considered. Hypotensive anaesthesia was given to minimise the blood loss and reducing the risk of aspiration. Tube change with tracheostomy tube was done after the patient was completely conscious and adequate muscle recovery was established keeping emergency airway cart ready anticipating false passage risks.

## Conclusion

In cases of masses occluding the airway elective tracheostomy is a better method of securing the airway as opposed Fiberoptic technique

## References

1. McGrath BA, Bates L, Atkinson D, Moore JA. Multidisciplinary guidelines for the management of tracheostomy and laryngectomy airway emergencies. Anaesthesia 2012; 67: 1025–41
2. Peterson GN, Domino KB, Caplan RA, Posner KL, Lee LA, Cheney FW. Management of the difficult airway: A closed claims analysis. Anesthesiology. 2005;103:33–9
3. American Society of Anesthesiologists Task Force on Management of the Difficult Airway. Practice guidelines for management of the difficult airway. Anesthesiology. 2013;118:251–70