

Anaesthetic Management of Multiple Facial Injuries with Challenging Airway

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Abstract: *Multiple facial injuries while providing general anaesthesia creates unique airway problems in which mask ventilation and laryngoscopy may be difficult. Airway management is very critical factor in these patients. Awake fibre optic intubation is the procedure of choice in anticipated difficulty in intubation.*

Keywords: Facial injuries, anticipated difficulty in intubation, fibre optic intubation

1. Introduction

Multiple facial injuries, while providing general anaesthesia creates unique airway problems in which mask ventilation and laryngoscopy may be difficult. Airway management is a very critical factor in these patients. Awake fiberoptic intubation is the procedure of choice in anticipated difficulty in intubation.

2. Case Report

A 22 year old male patient presented to the plastic surgery department with multiple facial injuries. He was scheduled for facial reconstruction under general anaesthesia. In the pre anaesthetic evaluation no comorbidities, no allergies were stated. There were no alterations in blood analysis and coagulation tests.

The patient was having challenging airway with mouth opening of one and half finger and also depressed nasal bone fracture. Patient was shifted to operating room and standard monitors electrocardiogram, non invasive blood pressure monitoring, pulse oximetry were connected. 18G cannula secured on left dorsum of hand.

Premedication given with inj. Glycopyrrolate 0.2mg i. v, inj. Rantac 50mg, i. v, inj. Ondansetron 4mg i. v.

Bilateral superior Laryngeal nerve block given with 25G needle with 3ml of 1% lignocaine and transtracheal block given with 2ml of 4% Lignocaine.

After placing the 8 mm ID flexometallic endotracheal tube with fiberoptic bronchoscope through oral cavity and confirming its position with sustained etco₂, loss of phonation, reservoir bag movement inj. Midazolam 1mg iv, inj. Fentanyl 100micrograms i. v, inj. Thiopentone 300mg i. v, inj. Vecuronium bromide 4mg i. v given. Connector end was placed submentally.

Maintenance done with nitrous oxide, oxygen and sevoflurane. During the procedure patient was hemodynamically stable.

post operatively patient was kept in respiratory intensive care unit and extubated after two days.

3. Conclusion

Fiberoptic intubation is the best choice in cases of difficult airway as in this procedure we keep the patient awake and breathing spontaneously. As it is under direct vision and also the presence of depressed nasal bone fracture in this patient, compared to blind nasal intubation it is better choice. So while anaesthetizing in operation theatre or intubating in emergencies with anticipated difficulty we have to choose fiberoptic intubation.

