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Airway Management in a Child Developing Laryngomalacia after SISTRUNK Surgery

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1. Case History

- A 2 year old male child presented with a swelling in front
 of neck since5 months, gradually increasing in size,
 patient underwent surgery of incision and drainage for
 same under GA 6 months back where he was transfused
 with 1PRC, but patient again complained of watery
 discharge from the incision site
- Now patient was posted for thyroglossal cyst excision

Birth history

Not significant

After taking consent of parents, patient was taken on OT table, monitors were attached, vitals noted and IV fluid was started O/e GC fair, pt was conscious, a febrile, alert with vitals—pulse 100/min BP— appwf, spo2 100%, airway examination showed no obvious craniofacial anomaly, and systemic examination was WNL

Investigations

CBC9.4/10100/276000 RFT 14/0.5

SE 139/3.7

Pt was advised to keep adequate NBM, for the next day of surgery

VLSCOPE image showing left sided swelling near left vocal cord

After the procedure, and looking after spontaneous efforts of respiration of patient, pt was reversed with Inj neostigmine 0.06mg/kg IV, injglycopyrrolate0.008mg/kg IV and patient was extubated.

Premedication were given with Injfentanyl 2mcg/kg, Injglycopyrrolate 0.004mg/kg and anesthesia was induced with Sevoflurane +O2 using muscle relax antinjatracurium

Using direct laryngoscope, Pt was then intubated with ET tubeno 5 (uncuffed), with blackline at level of cords, air entry was confirmed, rechecked after fixation, and anesthesia was maintained on O2+Air+Sevoflurane+intermittent injatracurium on closed circuit mechanical ventilation. Patient was vitally stable throughout the procedure

After extubation, patient developed stridor after 5 mins, chest retractions were present along with nasal flaring. Sp02 dropped to 86%, patient was reintubated now with 4.5 no ETtube using videolaryngoscope

After monitoring for 1 hour, Pt was extubated, but again pt developed similar symptoms and therefore intubated with ET tube 4.5 using videolaryngoscope

Patient was shifted on O2trolley with ambu ventilation to ICU and was put on ventilator and decision to extubation was withhold for few hrs.

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ICU Monitoring and Evaluation Bronchoscopy in ENTOT

Patient was put on VOLAC mode of ventilation with parameters 50%/90/0.4/20/5 and was started on infusion of Inj midazolam 0.02mg/kgIV + inj fentanyl 2mcg/kg IVfor sedation Patient was monitored for 2days in ICU, proper endotrachealtube suction and care wastaken, nebulization was given andPatient was posted for evaluation bronchoscopy. Patient wasshifted on O2 trolley withambu ventilation to ENT OT on3rdpostoperative dayand was taken on OT table after takinghigh risk consent

After doing bronchoscopy, findings were Right vocal cord mobile with left vocal cord palsy, no laryngeal edema

Pt was extubated and observed in ENT OT recovery for 2hrs.



After shifting toward 1A, patient again developed chest retractions with RR of 54/min, pulse 180/min and patient was febrile with temperature of 38 degC



Decision was taken for patient to put On HFNC 15L O2/min, 60%FiO2



Patient tolerated HFNC and improved after 2hrs along with giving lateral and prone positioning intermittently, patient gradually weaned off wherein RR was 22/min, pulse 140/min with minimal chest retractions

2. Case Discussion

Use of HFNC in this case proved a beneficial thing for this child, otherwise the child would have to be reintubated again and further complications would have occurred. Hence, ventilator associated infections were bypassed. In addition to that reintubation might have aggravated the child's status.

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