A rare cause of desaturation in an infant after anesthesia induction

Sir,

We here report a rare cause of desaturation in an infant after induction of general anesthesia. A 2-month-old boy weighing 3.2 kg was posted for exploratory laprotomy and cardiomyotomy for pyloric stenosis after obtaining informed written consent. The boy was resuscitated and gastric lavage was done using size 10 Fr feeding tube prior to surgery. On the operation theater (OT) table, child was coughing occasionally but chest was clear. Room air saturation was 97%. After suctioning the nasogastric tube which did not reveal any content, rapid sequence induction was

planned. After induction, child desaturated immediately upto 40%. So, gentle positive pressure ventilation was attempted. There was significant resistance and required higher airway pressures to ventilate the child. As there was no improvement in ventilation with use of airway and appropriate mask holding, decision to intubate was taken. Laryngoscopic visualisation was difficult and required release of cricoid pressure. It was observed that the nasogastric tube was in the trachea. The feeding tube was immediately removed and patient's trachea was intubated. There was minimal aspiration which was suctioned from trachea. Oxygen saturation improved to the previous value and auscultation of the chest did not reveal any added sounds. Surgery went uneventful and patient trachea was extubated. On retrospective analysis of what had happened, it was revealed that the feeding tube got accidentally removed, so reinsertion of the tube was done before shifting the child to the OT.

In the literature, pneumthorax,[1] laryngospam,[2] and lung laceration[3] have been reported because of inadvertent nasogastric tube insertion. In our knowledge, this is the first case which reported nasogastric tube malpositioning leading to desaturation in an infant after anesthesia induction. The situation become more worse in neonates and infants after anesthesia induction, as they desaturate quickly and more vulnerable to hypoxaemia.[4] Proper assessment of patients for positioning of nasogastric tubes should be done before induction of anesthesia on the OT table.[5]

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Conflicts of interest
There are no conflicts of interest.

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