

A failure of pre-anaesthetic check-up leading to unsuspected difficult intubation

Sir,

Unanticipated difficult airway during anaesthesia is associated with increased morbidity and the ensuing hypoxia could lead to brain damage and even death.^[1] An important purpose of pre-anaesthetic check-up is to predict a difficult airway. Errors and omissions during pre-anaesthetic check-up and anaesthesia administration have been extensively reported. Checklists have been developed to decrease errors associated with anaesthesia circuits and drug delivery.^[2] Here, we report a case where the presence of hoarseness was missed on pre-anaesthetic check-up leading to an unanticipated difficult intubation. Through our experience, we wish to emphasise the importance of communicating directly with the patient and incorporating vocalisation in the pre-anaesthetic checklist as a part of airway assessment.

A 46-year-old female was scheduled for elective day care laparoscopic cholecystectomy. During pre-anaesthetic assessment, history was taken from her son as she did not understand the local language. The patient was a hookah smoker, who had intermittent episodes of wheezing that responded to bronchodilator therapy. Her current physical and airway examination were unremarkable. After prophylactic nebulisation with salbutamol, anaesthesia was induced with fentanyl (2 µg/kg) and propofol (1.5 mg/kg). Vecuronium (0.1 mg/kg) was administered to attain neuromuscular blockade. On direct laryngoscopy with Macintosh size 3 blade, a 1 cm × 1.5 cm globular mass was seen over the rima glottidis, completely obscuring the laryngeal inlet [Figure 1]. All attempts to pass the endotracheal tube beyond it failed. Since mask ventilation was possible, we decided to proceed with fibre-optic-guided tracheal intubation using which we could negotiate the growth. The desired surgery was conducted. At the end of surgery, trachea was extubated after the patient was awake and neuromuscular blockade was adequately reversed.

It was discovered later that patient had long-standing hoarseness of voice which was missed since history was taken from attendant. Otorhinolaryngologist's

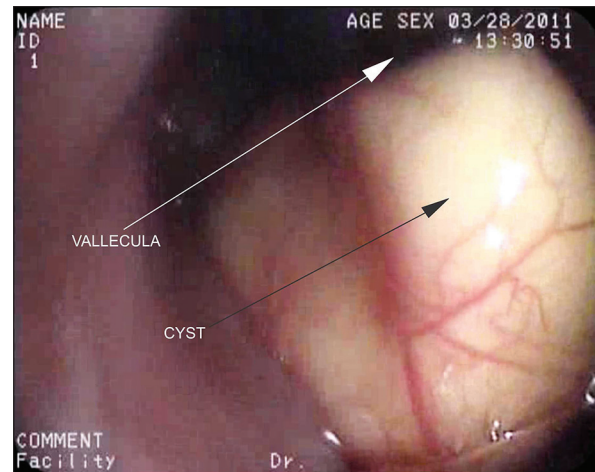


Figure 1: Epiglottic cyst seen on fibre-optic bronchoscopy

reference was sought for further management of cyst and provisional diagnosis of 'laryngeal cyst of epiglottic origin' was made. Although epiglottic cysts may be asymptomatic, symptoms of hoarseness, foreign body sensation, dysphagia or snoring should alert the anaesthesiologist for further evaluation.^[3] Pre-operative hoarseness of voice should be documented and evaluated by indirect laryngoscopy to find out the cause. Although our patient had both hoarseness of voice along with bronchial asthma which is strongly attributed to a laryngeal cyst when present together,^[4] the correlation was missed. Due to shortage of time to evaluate patients between cases and availability of a relative with our patient, history was not taken from the patient and the presence of hoarseness was completely unnoticed. In our patient, fortunately, there was no difficulty in bag and mask ventilation; however, a pedunculated growth could have caused complete airway obstruction post-induction with failure to ventilate.^[5]

Airway assessment is an essential part of pre-anaesthetic management; the failure to anticipate a difficult airway can lead to disastrous complications. Through our experience, we would like to emphasise that interacting directly with the patient and vocalisation are the sine qua non of airway assessment. In the current era of medical tourism, language barriers are frequently encountered. An informant or a translator cannot be a substitute for hearing the patient's voice.

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Conflicts of interest

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