

When everything failed, glidescope prevailed

Sir,

We report the successful management of an unanticipated difficult airway secondary to an asymptomatic large vallecular cyst obscuring the glottic opening using glidescope after repeated failed attempts at mask ventilation and laryngoscopy.

A 70-year-old, 60 kg, American Society of Anesthesiologists (ASA) I male patient was scheduled to undergo re-exploration for persistent bleeding following transurethral resection of the prostate. The preanesthetic checkup and airway examination was unremarkable. General Anesthesia was planned in view of ongoing blood loss. Patient was shifted to the operating room and connected to the multichannel monitor (Datex-Ohmeda, Finland). Intravenous access (i.v.) was established with 18G cannula, and i.v. glycopyrrolate 0.2 mg and morphine 6 mg was given. Patient was preoxygenated with 100% oxygen for 3 min and then induced with sleep dose of thiopentone. After confirming assisted mask ventilation, i.v. vecuronium (0.1 mg/kg) was given but, immediately after full muscle relaxation was achieved, absent capnography trace along with minimal movement of the chest was noticed. Guedel's airway was inserted, mask position and adequate seal reconfirmed and any leaks or equipment failure was ruled out. With failure to ventilate even now, it was decided to perform direct laryngoscopy to facilitate endotracheal intubation. Meanwhile, the anesthesia technician was also requested to bring a glidescope as the fiberoptic bronchoscope was not available. Since the patient was routinely preoxygenated with 100% oxygen, the SpO₂ could be maintained at around 93% throughout till successful intubation could be accomplished. A large vallecular cyst was detected arising from the right vallecula obscuring the glottic opening entirely [Figure 1]. After two unsuccessful attempts to visualize the glottis, it was decided to use glidescope which revealed a small aperture glottic opening, distorted and displaced by the cyst. 7.0 mm cuffed oral endotracheal tube was passed beyond the cyst into the trachea and confirmed by capnogram. The cyst was then aspirated to prevent any problems at extubation. Patient was maintained on controlled ventilation using 66% nitrous oxide in oxygen with 1% isoflurane. He also received i.v 8 mg of dexamethasone following intubation. The surgery continued uneventfully for 1 h. At the end of surgery, neuromuscular blockade was reversed with 50 µg/kg of i.v neostigmine and 10 µg/kg of i.v glycopyrrolate. His trachea was extubated uneventfully. He was then shifted to postanesthesia care unit and discharged from the ward 2 days later.

Glidescope is a new addition to the armamentarium for managing a difficult airway. Although it has been used to



Figure 1: Vallecular cyst obstructing the laryngeal inlet

achieve primary airway control in anticipated, symptomatic large vallecular cyst,^[1] it also helps in unanticipated difficult airway by improving the Cormack-Lehane grading and making part of the airway visible. By virtue of its inherent design of bent tip at 60°, the structures that are obscured on direct laryngoscopy may be readily observed with the use of glidescope.^[2,3] It is already established that the use of glidescope has a high success rate in both primary airway control as well as failed direct laryngoscopy.^[4] The ASA difficult airway guidelines have also incorporated glidescope for improved laryngeal view and increased successful intubations.^[5]

This equipment use avoids multiple attempts at successful tracheal intubation. Therefore, it may be used as a tangible alternative device in a situation where tracheal placement seems to be rather difficult or impossible.

**Richa Saroa, Sukanya Mitra, Shradha Sinha,
Anjali Singh**

Department of Anaesthesiology and Critical Care, Government Medical College and Hospital, Chandigarh, India

Address for correspondence: Dr. Richa Saroa,
Department of Anaesthesiology and Critical Care, Government
Medical College and Hospital, Chandigarh - 160 030, India.
E-mail: richajayant@rediffmail.com

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