Oro-facial dysmorphism with visible glossoepiglottic fold in a heteropagus: First description

Sir,

I would like to congratulate Gosavi *et al*. on successful anaesthetic management of a difficult and rare case.[1] We provided perioperative care to a patient with nearly the same rare congenital anomaly. Though this patient did not pose any added anaesthetic challenge, we observed some very interesting findings during airway assessment.

A 6-day-old term male baby weighing 3.6 kg was brought to our institute with the complaints of a foetus like mass protruding from his tongue and difficulty in feeding. Examination revealed that an acephalic and acardiac twin (parasitic twin) was attached to the tongue of the autosite [Figure 1 Panel-I]. The autosite had left sided broadened ala, atresia of left anterior nares, misaligned alveolar ridges and thinned out lips. Oral aperture was broadened along with cleft lip. A projecting ridge like structure from left upper alveolus along with malformed palate was also noted. Tongue was thin, broadened and leaf like. It was under tension because of the weight and position of the parasitic twin. Right palatoglossal fold was not well delineated, whereas left palatoglossal fold was well-formed with a small, conical, fleshy mass (probably uvula) attached to its medial end. The epiglottis along with the glossoepiglottic fold was visible [Figure 1 Panel-II]. No other comorbidity was evident. Paediatric fibreoptic intubation device was not available at our institute at that time. As the oral isthmus was large, we decided to perform an indirect laryngoscopy. It revealed easy visualization of glottic opening. Subsequently excision of the parasitic twin was carried out under general anaesthesia with endotracheal intubation without any adverse event. Endotracheal intubation was easy as suggested by the view obtained during indirect laryngoscopy.

Heteropagus twinning is rare congenital anomaly and estimated incidence is approximately 1/1 million live births.[2] This is an interesting case, as until date to best of our knowledge no description of a heteropagus twin joined at the tongue of the autosite has been reported. Visibility of glossoepiglottic fold during preoperative airway assessment in this case is another unique description. Although elongated and/or omega shaped epiglottis is commonly described in patients with visible epiglottis, in this case it was shortened, truncated and omega shaped.[3]

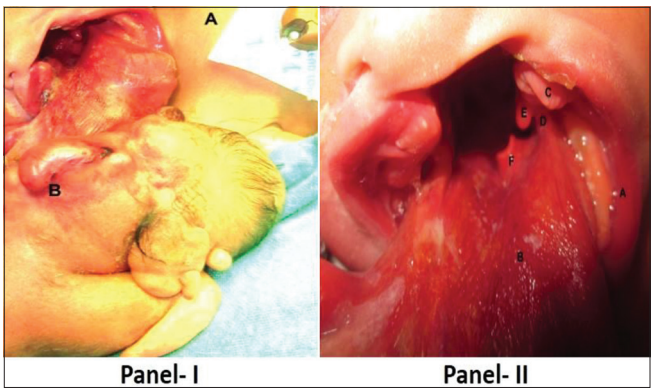

Figure 1: Panel-I parasitic twin attached with the tongue of the autosite. (A) Autosite, (B) Parasitic twin. Panel-II oral cavity of the autosite. (A) Lip, (B) Tongue, (C) Ridge like structure from left upper alveolus, (D) Left palatoglossal fold, (E) Small, conical, fleshy mass (probably uvula), (F) Epiglottis along with glossoepiglottic fold

Unlike this case, elongated and visible epiglottis may be normal variant in paediatric age group.[3] Visualisation of epiglottis upon mouth opening and protrusion of tongue, i.e. Mallampati Class zero airway, is associated with easy intubation in paediatric age group and possibly the 5-year-old boy described by Mehta *et al*. is the youngest reported to have Class zero airway.[4] Chou and Wu have provided their hypothesis to explain the reasons behind Class zero airway.[5] In our patient, we believe that increased oropharyngeal space due to the dysmorphic features along with the tension over the thinned out tongue have contributed to the visualisation of epiglottis along with glosso-epiglottic fold.

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