Airway management for oral surgery in a patient with repaired cleft palate

Sir,

Sharing airway with surgeon is always challenging for anesthesiologist. However, the preexisting airway defect would certainly add more problems to it. Here, we have highlighted such an issue in patient with preexisting palatal defect who was posted for oral surgery.

Otherwise healthy female was diagnosed as a case of benign growth of tongue and scheduled for wide local excision of right lateral border of tongue. She had been operated for repair of cleft palate at the age of 18 month and still had a peanut size defect in the midline of soft palate. There was neither an associated upper respiratory tract infection (URTI) nor airway obstruction like symptoms. Surgical procedure required nasal intubation for the case; however, in view of existing soft palate defect, a decisive dilemma emerged regarding the management of airway. Standard monitors were attached. After standard anesthetic induction, nasal intubation was carefully performed through left nostril and trachea was intubated with 7.5 mm flexomettalic tube under fibreoptic bronchoscopy (FOB). A Ryle's tube was also inserted under Glidoscope view without causing injury to soft palate. Rest of the intraoperative course was uneventful and at the completion of surgery, trachea was extubated. The patient was shifted to postoperative recovery unit.

In general, nasal intubation is not advocated in patients with previous cleft palate surgery in childhood and even if it is required then it has to done on the opposite side of defect.[1,2] Since the defect is in midline in our case and nasal intubation was required, we opted for intubation using FOB. The alternate method of intubation is also described in the literature.[2] The anatomy of the nasopharynx as well as oropharynx usually gets altered after the cleft palate repair and increases the difficulty during nasotracheal intubation.[3] It also carries a risk of damage to the repaired palatal defect. Although considered being a gold standard, FOB has its own limitations in such conditions. It requires the expertise to assess the size of the nasopharyngeal ports and passing the scope into the oropharynx without further traumatizing the nasopharyngeal structures. Moreover, in conditions with secretions and bleeding, it becomes difficult to visualize by FOB.

In summary, airway management in patients with previous cleft palate surgery will always be a challenge for the anesthesiologist and will influence the method of airway control. Thorough preoperative assessment to rule out persisting palatal defect coupled with judicious implementation of knowledge and skill is needed to avert the unwanted complication.

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REFERENCES

1. Solan KJ. Nasal intubation and previous cleft palate repair. Anaesthesia 2004;59:923-4.
2. Hee HI, Conskunfirat ND, Wong SY, Chen C. Airway management in a patient with a cleft palate after pharyngoplasty: A case report. Can J Anaesth 2003;50:721-4.
3. Schliephake H, Donnerstag F, Berten JL, Lönquist N. Palate morphology after unilateral and bilateral cleft lip and palate closure. Int J Oral Maxillofac Surg 2006;35:25-30.

Access this article online	
Quick Response Code:	Website: www.saudija.org
	DOI: 10.4103/1658-354X.121072