

posted for excision of a mass arising from the tongue under general anaesthesia [Figure 1]. The magnetic resonance imaging revealed a mass lesion measuring 3.5 cm × 3.2 cm in the posterior aspect of the oral cavity [Figure 2]. Neck extension and other physical examinations were unremarkable and laboratory investigations were within the normal limits.

Orotracheal intubation under local anaesthesia with sedation was planned due to fear of complete airway obstruction on induction of general anaesthesia.^[2] A nasotracheal intubation would have been more appropriate from the surgical point of view, but was avoided due to risk of inadvertent injury to the tumour. The procedure was explained to the patient and consent for possible tracheostomy was obtained.

After instituting routine monitoring, glycopyrrolate 0.2 mg and fentanyl 50 µg were administered.



Figure 1: Mass arising from the tongue

Comment: Molar approach with backward, upward, right and posterior manoeuvre

Sir,

The article by Sharma *et al.* highlights the importance of innovation in dealing with a difficult airway, especially when gadgets like fiberoptic bronchoscope are not available.^[1] We present the approach undertaken by us in a somewhat similar situation.

A 28-year-old male, of 54 kg body weight, was

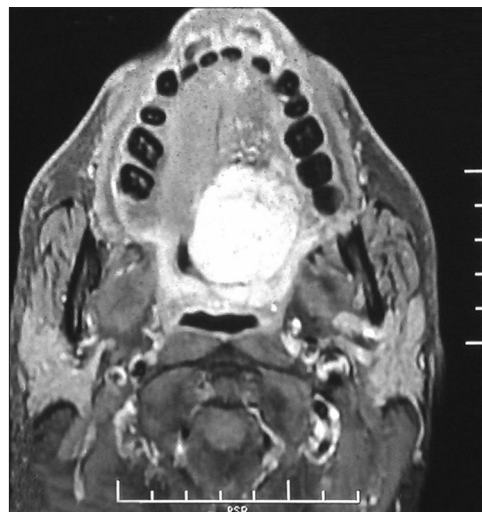


Figure 2: Magnetic resonance imaging showing the extent of the mass

Dexmedetomidine 50 µg was infused over 10 min. Patient was under constant monitoring for a possible excessive sedation jeopardising the airway. A nasal catheter was inserted into the right nostril and oxygen flow was started at 3 L/min after spraying the oral and nasal cavity with a total of six puffs of lignocaine 10%.

Direct laryngoscopy with a Magill's blade using the midline approach revealed only the tumour mass. Now, the right molar approach was used. The posterior rim of the glottis was visualised after external laryngeal manipulation using backward, upward, right and posterior (BURP) manoeuvre. Tracheal intubation was performed successfully using a 7.0 mm ID cuffed endotracheal tube mounted over a bougie and was confirmed by bilateral chest auscultation and capnography. General anaesthesia was administered immediately after this using propofol and vecuronium. The course of anaesthesia and surgery were uneventful.

Meticulous planning, help of appropriate radiological investigations to visualise the extent of mass lesion, use of multimodal analgesia and/or sedation and use of different manoeuvre and techniques can help manage such cases even in the absence of sophisticated equipment. However, patient co-operation and preparedness for an emergent tracheostomy is paramount.

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