

Positioning dilemma in a complicated case. Utilizing OT table for ingenious positioning

Dear Editor,

Surgical positioning in patients with intercostal drainage (ICD) tubes can cause immense pain and discomfort. The lateral decubitus position is preferred for surgery of elbow fractures.^[1] Providing adequate surgical exposure in an awake patient while avoiding any risk of airway compromise is a challenge for the anesthesiologist, especially in patients with difficult airways. Herein, we report such a case. A 64-year-old male weighing 90 kg presented with fractures of the left clavicle, bilateral ribs, and left olecranon with elbow dislocation following a road traffic accident (RTA) 20 days ago. ICD tube was placed in view of the hemopneumothorax on the right side. He also had retropulsion of the second cervical vertebra with an increased gap between the atlantoaxial joint for which the cervical collar was placed. The patient was posted for olecranon fracture repair. Our anesthesia plan was supraclavicular brachial plexus block with sedation, so as to avoid airway instrumentation and positive pressure ventilation (PPV) in view of preexisting hemopneumothorax and cervical spine trauma. Under all aseptic precautions, the block was performed using ultrasound. Intravenous (iv) fentanyl (100 µg) and dexmedetomidine infusion in titration (0.2–0.5 µg/kg/h) were used for sedation.

Since the patient had to be positioned in the right lateral decubitus, which is the same side as the ICD tube in the midaxillary line, there was a risk of ICD tube kinking. Our operation theatre (OT) table has two detachable leg ends with a small gap in the middle [Figure 1a]. We planned to use this design to our advantage by reversing the direction so that head of the patient is placed toward the leg end of the OT Table [Figure 1b]. Advantage of this was that we could carefully position the patient in such a way that the ICD insertion site was safely placed in the gap between the two leg ends of the OT table [Figure 1c-e]. Analgesia for the ICD site was achieved by intrapleural injection of 5 mL of 2% lignocaine inside the ICD^[2-4] and clamped for 2 min. The patient was carefully positioned in the lateral decubitus position as described above. The insertion site of the ICD tube was confirmed to be freely placed in the gap-opening of the OT table, without any kink and ensuring normal fluid column movement in the tube. Analgesia was supplemented with

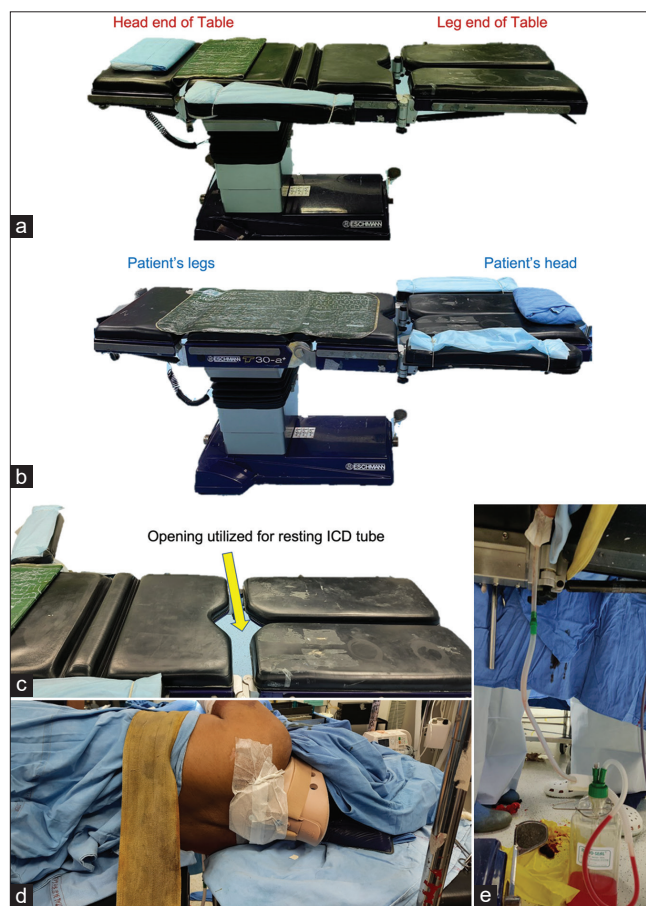


Figure 1: OT table Ingenious Positioning. (a) Normal OT Table Orientation, (b) OT Table repositioned to accommodate the Chest Drain Tube, (c) Opening in OT Table planned for position of Chest Tube (d) Patient in lateral position with Chest Tube in situ (lateral view), (e) Patient in lateral position with Chest Tube in situ (bottom view)

paracetamol 1 g, ketorolac 30 mg, and dexamethasone 16 mg iv. Throughout the perioperative period, continuous verbal communication was maintained with the patient ensuring his comfort along with maintaining inline stabilization of the cervical spine and proper care of ICD. Vitals were stable throughout the perioperative period.

To summarize, patient comfort and safety are our priorities. In patients having complex multiple fractures, the use of multimodal analgesia technique and available resources in nonconventional and innovative ways can facilitate us using regional anesthesia over general anesthesia. Here, we used the OT table in a unique manner along with multimodal analgesia for the patient comfort and safety.

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Conflicts of interest

There are no conflicts of interest.

**Nikita Choudhary, Abhishek Nagarajappa,
Puneet Khanna, Sarina Karayi**

Department of Anaesthesia, Pain Medicine and Critical Care, All India
Institute of Medical Sciences, New Delhi, India

Address for correspondence: Dr. Nikita Choudhary,
SR Anaesthesia, Department of Anaesthesiology, Pain Medicine and
Critical Care, AIIMS, New Delhi - 110029, India.
E-mail: choudhary.20nikita@gmail.com

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