



Figure 1: Computed tomography head and neck showing deviation and severe constriction of the trachea with arrow

Difficult flexible fibre-optic bronchoscopy: Assist it with video laryngoscopy!

Sir,

A 52-year-old male in stridor, known case of carcinoma of the thyroid with recurrence, presented to our Institute's Emergency Department. He was rushed to the operating room, with continuous oxygen supplementation, for tracheostomy with oxygen saturation of 86% and tachycardia. On the assessment, a difficult intubation was anticipated. Neck examination revealed a hard mass in the neck, restricted neck movements due to mass on the anterior aspect and trail's sign negative with adequate mouth opening and modified Mallampati class II. His computed tomography scan neck [Figure 1], 3 days prior showed a deviated and narrowed; "dew-drop shaped" trachea. Surgeons refused to do a tracheostomy unless the patient was intubated, in view of a "stone hard" mass surrounding the entire airway and deep tissue infiltration. A video laryngoscopy was performed using Glidescope® (Verathon) showing the epiglottis, pharynx and larynx infiltrated with tumour. Intubation was not attempted for the fear of bleeding and further damage to the vocal cords. Spontaneous ventilation with oxygen supplementation was continued using nasal prongs. An awake flexible fibre-optic bronchoscopy was performed through the right nostril and video laryngoscope was introduced

to identify the glottic opening because it was difficult to identify the tracheal rings with the bronchoscope due to tumour invasion. A 6.5 mm endotracheal tube was inserted over the flexible fibre-optic scope under vision of the video laryngoscope and ventilation was restored. The entire process took us a total of 12 min. A successful tracheostomy was performed with the endotracheal tube as a guide for the surgeons to identify the trachea through the tumour mass. This technique of video laryngoscopy assisted fibre-optic intubation can be utilised in many difficult situations where use of single technique may fail to identify the both the glottic opening and the trachea. A PubMed search revealed a reference of Glidescope assisted fibre-optic intubation in 2005;^[1] in 2006, a series of 13 patients were intubated using this technique, they were predicted difficult airways for elective procedures.^[2] A similar technique was performed in a patient with a large vallecular cyst where the glottic opening could not be identified.^[3] This technique can be included as part of difficult airway algorithm^[4] in an emergency situation where it would be difficult to identify the glottic opening and tracheal rings, as in the present case, where we encountered a difficult laryngoscopy, intubation and surgical access.

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