A 7-year-old, 22kg girl presented with progressive worsening voice changes, dysphagia, and obstructive breathing at night over several weeks.

ENT performed a flexible nasopharyngoscopy that showed a large mass at the base of the tongue but could not visualize the laryngeal introitus or vocal cords.

CT imaging confirmed a large heterogeneous mass emanating from the epiglottis obstructing the laryngeal introitus (Figure 2).

ASA DIFFICULT AIRWAY ALGORITHM

4. Develop primary and alternative strategies:

AWAKE INTUBATION

- Airway approached by Nonintubation
- Involved Airway access

CASE DESCRIPTION

- Consulted SPA Pedi-R members via Whatsapp. Most suggested to proceed with mask induction followed by intubation/tracheostomy attempts.
- Endotracheal intubation and induction of anesthesia (IV or Mask) was perceived as too dangerous due to impending airway obstruction.
- Primary plan for awake surgical airway with minimal sedation if needed.
- Back up plan to induce anesthesia followed by emergency tracheostomy.
- Discussed plan with entire team (family, patient, ENT, anesthesiology, critical care, OR nursing, and child life specialist).
- Proceeded with surgery in evening due to concerns for progression of airway obstruction and acute desaturation overnight.
- OR Team pre-procedure huddle outlined roles and responsibilities prior to transport.
- EMLA cream was applied over neck prior to transport to OR.
- The child was cooperative during transport to the OR, positioning on OR table, undergoing skin prep with betadine, and placement of surgical drapes. During the procedure, she was responsive and watching “Frozen” until tracheostomy secured (Figures 3,4).
- Mass visualized by rigid bronchoscopy after tracheostomy (Figure 5).

REFERENCES


DISCUSSION

- Think outside the box.
- Team communication and collaboration are critical.
- Allow team members to speak up for concerns/safety.
- Procedures with minimal sedation / monitored anesthesia care in a pediatric operating room can be very stressful to the patient and OR staff.
- Leverage pediatric anesthesia community resources - Consulting pediatric difficult airway specialists from multiple institutions via established pathways (group messaging/social media apps).

PRE-OPE Rate ASSESSMENT

- A 7 year-old, 22kg girl presented with progressive worsening voice changes, dysphagia, and obstructive breathing at night over several weeks.
- ENT performed a flexible nasopharyngoscopy that showed a large mass at the base of the tongue but could not visualize the laryngeal introitus or vocal cords.
- CT imaging confirmed a large heterogeneous mass emanating from the epiglottis obstructing the laryngeal introitus (Figure 2).