

Awake Intubation of Difficult Airway for A Patient Posted for Revision Lip Reconstruction Surgery – A Case Report

Dr. Vishnuvanditha Vuppuluri¹, Dr. Senthil K. S², Dr. Lakshmi³

¹Postgraduate, Dept of Anaesthesia, Saveetha Medical College

²Assistant Professor, Dept of Anaesthesia, Saveetha Medical College

³Head of department of Anaesthesia, Saveetha Medical College

1. Introduction –

Awake intubation is usually performed electively in the presence of a difficult airway. When faced with an anticipated difficult airway, the anaesthesiologist needs to consider securing the airway in an awake state without the use of anaesthetic agents or muscle relaxants. As this can be highly discomforting to the patient, time and effort must be spent to prepare such patients both psychologically and pharmacologically for awake intubation.

Case Report –

60 year old male came with complaints of lower lip swelling for the past 20 days. FNAC was done which showed squamous cell carcinoma. Patient was posted for revision lower lip reconstruction surgery.

Past History –

Patient is a known case of squamous cell carcinoma of lip for the past 3 months. After diagnosis patient was posted for lip reconstruction surgery with PMMC flap. Patient received 28 cycles of radiation therapy over one month following which he noticed a small swelling on his lower lip.

FNAC was done and the patient was diagnosed with squamous cell carcinoma of lower lip. Patient presented with inadequate mouth opening of 1 finger breadth and was planned for awake fiberoptic intubation for revision lip reconstruction surgery.

Intraoperative Management –

Pre-operatively before shifting patient into the OR, patient was nebulized with 4ml of 4% lignocaine for 15 mins to anesthetize the airway. Following which a nasal pack was inserted which was already soaked in 2% lignocaine, this was left for about 10 mins. Patient was educated and informed consent was taken before intubation. Nasal airway was inserted and patient was pre-oxygenated. Patient was given inj glycopyrolate 0.2mg IV and inj midazolam 1mg IV. Fiber-optic was introduced nasally and cords were visualized. Size 7 cuffed ETT was introduced via the fiber-optic, cords were crossed. Fiber-optic was removed and air entry was checked bilaterally. Patient was induced with inj fentanyl 100mcg IV and inj propofol 100mg IV and paralyzed with inj atracurium 20mg IV. Intraoperative hemodynamic stability was maintained with adequate ventilation.

Patient was reversed with inj neostigmine 2.5mg IV and inj glycopyrolate 0.5mg IV. Spontaneous ventilation was achieved. Patient was extubated uneventfully.

2. Discussion

Endotracheal intubation is one of the basic lifesaving skills that an anaesthesiologist possesses. Its performance begins with a detailed airway assessment for identifying a difficult airway. Based on the findings of the airway examination and a focused medical history, the anaesthesiologist decides whether the intubation is best performed safely in the awake state or the patient could be given the benefit of general anaesthesia without muscle relaxation. Essential monitoring and preoxygenation constitute a part of the sequence of endotracheal intubation. The details of providing topical anaesthesia (when awake intubation is considered) or general anaesthesia without muscle relaxation (in an extremely anxious individual with a potentially difficult airway) are covered in the latter part of this review. Proper patient preparation by an empathetic anaesthesiologist goes a long way in making the procedure of awake intubation acceptable for all concerned.