

The Patient with a Known Difficult Intubation for Facelift

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Patient O.T.

- Healthcare worker, desires facelift at freestanding ASC. Cancelled 2 months previously because of URI.
- Known difficult intubation from only other surgery where with routine induction, failed laryngoscopy led to fiberoptic intubation (anterior larynx by report).
- Request case by attending plastic surgeon.

Preop continued

- Discussed sedation technique with spontaneous ventilation and no intubation.
- Discussed that if this was not possible, then might need LMA.
- Might need fiberoptic intubation while asleep, or might even require waking up with awake fiberoptic intubation.
- Patient understood and agreed.

Intraop

- Placed on OR table and given 1 mg Versed.
- Good effect from the Versed.
- Started Propofol/ Alfentanil drip at 60 cc/hr. Sedated with 7 cc.
- Lost CO2 tracing, returned with chin lift. No drop in saturation.
- Placed nasal trumpet with xylocaine jelly.
- CO2 tracing returns, but patient opens eyes to verbal stimulus.

Intraop

- Sedation continues with loss of CO2 tracing, placement of oral airway.
- CO2 tracing returns, but patient continues to open eyes to verbal stimulus.
- Discussion with surgeon about using LMA.
- Search for "flexible" LMA, none found.
- Placed #3 "rigid" LMA on 2nd try.
- Good CO2 tracing, patient unresponsive to verbal stimulus. Ready for surgery.

Intraop

- Good saturation, 35 minutes into the case.
- Positioning of circuit off head of OR table.
- Decrement in CO2 tracing, returns with circuit positioned to foot.
- Patient starts to cough, bolus propofol.
- Laryngospasm!!!
- Remove LMA, attempt to ventilate by mask with tight bag.

Intraop

- Push 120 mg Succinylcholine.
- Unable to ventilate.
- Laryngoscopy with MAC 4, no visualization tube into esophagus.
- Saturation 60%, Atropine for HR = 35.
- Laryngoscopy with straight blade, no visualization, tube into esophagus.
- Emergency trach, immediate CO2 obtained.

Intraop

- Trach revised, propofol drip, spontaneous ventilation returns, transported to SICU.
- Responds to commands in SICU.
- Sedated for several hours, but within 24 hours is completely awake, alert, with no deficits.

Near Follow Up

- Seen by me daily.
- Completed a "medic alert" bracelet for her stating "Difficult intubation. Needs fiberoptic awake intubation. Irritable airway with laryngospasm when sedated."
- Repeated detailed explanations of "what happened?"

Additional information

- Patient has history of "choking easily".
- Has required esophageal dilations on several occasions. Always with no sedation.
- Relatives give history of patient having a "very soft voice". "I really have to read her lips to understand her. It has been that way all her life"

Why didn't Succinylcholine work?

- Data from pharmacy relative to Quelicin: Stable for three months at temps up to 25 °C (77 °F).
- Loss of potency at room temp is 1% per week
- At 40 °C (104 °F) loss is 3.2% per week (takes 22 weeks to reach 50%).
- However, use within 24 hours of preparation is recommended by manufacturer along with discarding any unused solution.

Follow Up

- Trach downsized and removed on POD 12.
- Patient discharged without complaints on POD 13.
- Scheduled for return to plastics and consideration for facelift. Patient has been told that will need awake fiberoptic intubation.

Discussion

- Should all known difficult intubations receive fiberoptic GA and not sedation technique?
- Is the above dependent on the proposed procedure (surgical field avoidance)?
- Should all intended fiberoptic intubations be done in hospital OR's vs free standing ASC's?
- Should we use LMA's for GA on patients with a history of need for fiberoptic intubations?
- Is the above also dependent on the proposed procedure (surgical field avoidance)?