LETTER TO THE EDITOR

AWAKE FIBEROPTIC INTUBATION WITH TARGET-CONTROLLED INFUSION OF REMIFENTANIL IN EMERGENCY SURGERY

Dear Editor:

We present a case of predicted difficult intubation before emergency surgery for stercoral peritonitis.

Patient’s medical history was of a 61-year-old man with a malignant laryngeal tumor. He had multiple sequences of radiotherapy and chemotherapy before current episode. Two months before this episode he had inhalational pneumonia, which necessitated gastrostomy for feeding purpose. The current hospitalization was for acute abdominal pain, with an abdominal CT scan suggesting bowel perforation with stercoral peritonitis. Thereafter, emergency laparotomy surgery was to be performed. Preoperative anesthetic assessment confirmed the acute abdominal syndrome, blood pressure of 110/80 pulsation 120 per minute, temperature 39°C, whereas airway assessment was a predicted difficult intubation because of trismus (1-cm mouth opening), the presence of a laryngeal tumor, and an irradiated neck due to his previous treatments, expected difficult thyrocricoïd puncture or tracheostomy under local anesthesia. On arrival in the anesthetic room, IV access, nasal oxygen (2 L/min), and routine monitoring including heart rate, arterial pressure, and oxygen saturation were established. The patient complained of nausea despite an IV administration of odansetron in the emergency department. An attempt to secure a nasogastric tube was unsuccessful because of deviation due to the tumor and very important pharyngeal reflex. Aspiration through the gastrostomy brought about 50 mL of gastric fluid. The patient did not agree with awake fiberoptic intubation or tracheostomy; however, he agreed for awake fiberoptic intubation with some amount of fluid can be trapped. Anesthesiasts should always be aware of inhalation of gastric fluid even with a gastrostomy tube before aspiration, as another important message is that other options were very limited (orotracheal intubation impossible due to trismus, very important and painful reflexes yielding major discomfort, neck radiotherapy making intercricothyroid puncture and tracheotomy under local anesthesia, and awake fiberoptic intubation difficult or almost impossible). Another important message is that anesthetists should always be aware of inhalation of gastric fluid even with a gastrostomy tube before aspiration, as some amount of fluid can be trapped.

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REFERENCES