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Research Article

Difficult Airway Management of a Child with Embryonal Rhabdomyosarcoma on The Face

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INTRODUCTION:
• Difficult airway is defined as the clinical situation where a trained anaesthetist experiences difficulties with face mask ventilation, tracheal intubation or both.
• Children have a smaller functional residual capacity, greater tendency for airway collapse and it becomes more difficult in a child with mass involving the face.

CASE REPORT:
• 11 month old child with swelling on the right side of face since 3 months of age now reaching the size of approximately 13x10x8cm posted for trucut biopsy.
• Pre-Anaesthetic check up done. On examination child was alert and active. Airway could not be assessed. Systemic Examination and Blood Investigations were normal.
• PET CT shows- multilobulated heterogenous soft tissue mass extending superiorly upto EAC, anteriorly- inferior eyelid, medially- erosion and remodelling of ramus of mandible, posteriorly- into the posterior cervical triangle, inferior- submandibular space.

ANAESTHETIC MANAGEMENT:
• After obtaining informed written consent from the parents, child was shifted to OR.
• IV cannula was secured with 24G venflon. Difficult airway cart was kept ready.
• Preoxygenation started with 100% oxygen and oxymetazoline drops was applied on both nostrils, then 3.5mm size uncuffed ET tube was inserted into the left nostril and secured as nasopharyngeal airway.
• Inj. Glycopyrolate 40 mcg, inj. Dexamethasone 1mg, inj.Fentanyl 10 mcg iv given and then the child was induced with 8% sevoflurane on maintaining the spontaneous respiration, inj. propofol 10mg given.

• The vocal cords were visualized with the help of video laryngoscope c-mac and then the child was intubated with 4 mm sized uncuffed tube after spraying 10% lignocaine.

• Anaesthesia maintained with air, oxygen and sevoflurane. After the procedure, 3.5mm sized uncuffed ET tube secured
again as nasopharyngeal airway and extubated on table.

CONCLUSION:

• Airway management in child offers greater challenges to anaesthesiologists due to inherent anatomical and physiological factors.

• Successful management of the paediatric airway, both anticipated and unanticipated is facilitated by pre-procedure assessment and preparation and developing a management plan for the problem accordingly.

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