

Case Report

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During this short session we report the clinical case of a 70-year-old woman suffering from an aortic arch bleb (a focal outpouching of the aortic wall, a kind of localized chronic aortic dissection). She was admitted in our clinic for elective aortic bleb resection through large left posterolateral thoracotomy during femoral artero-venous cardiopulmonary bypass support. Five years before the patient had suffered from a base of tongue cancer treated with extensive surgical resection and adjuvant radio- and chemotherapy. The clinical course was later complicated by mandibular osteonecrosis and multiple infections requiring several ENT reoperations in a tertiary care center. During this period, anesthetists performed awake nasal fiberoptic intubations for all surgical procedures (for a total of 6 interventions over a 3-year period).

At our preoperative clinical examination, the patient presented several predictors of difficult intubation (i.e., severely reduced mouth opening with a fixed trismus, reduced cervical mobility with cervical and mandibular scars, tissue changes after radiation therapy).

Because of the firm patient refusal to undergo awake fiberoptic intubation, we were forced to explore alternative strategies. Such a demanding perioperative planning was rendered even more challenging by the surgical requirement of one lung ventilation. Therefore, we opted for a careful staged approach.

All different steps and their related issues will be explained during the session.

Multiple different and modern techniques were required and applied during this interesting and challenging case. In fact, we performed ultrasound examination of the neck with cricothyroid membrane localization before the induction of anesthesia and ensured effective pre- and peri-intubation oxygenation by Transnasal Humidified Rapid-Insufflation Ventilatory Exchange; we performed intubation by the aid of a non-channeled videolaryngoscopy and a specific malleable intubating guide. Lung isolation was obtained effectively through a flexitip endobronchial blocker.

We also put emphasis on non-technical skills such as strategic pre-briefing with the complete anesthesia Team, during which we focused on the anticipation of unexpected intubation and/or ventilation failure and also we planned alternative approaches and prepared for their prompt application.

Nowadays several strategies exist to approach the anticipated difficult airway. The chosen final strategy also depends on the specific clinical situation, the previous experience and

background of the senior anesthesiologist and of the center. A careful planning is crucial and technical and non-technical skills in difficult airway management should be acquired, regularly updated and maintained throughout the professional life.