Congenital Fibroepithelial Polyp: A Case Report of Difficult Airway

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Abstract A 9 month old child presented with a growth in the oropharynx for removal. Only complaint was distressed breathing on crying. It turned out to be a case of difficult paediatric airway that was managed well. A diagnoses of oesophageal fibro-epithelial polyp was made after histopathological examination.

Keywords Neonatal · Paediatric anaesthesia · Difficult airway · Congenital polyp

Introduction

As anaesthesiologists we are aware that many a times, paediatric intubations turn out to be difficult, and we may land up with an unanticipated difficult airway [1]. Paediatric population is more at risk for hypoventilation and hypoxia if intubation during anaesthesia is delayed and ventilation is inadequate. An expected “normal airway and intubation” may take an ominous turn to CICV.

We are reporting a very unusual case of the same.

Case Report

A child of 9 months born of normal vaginal delivery presented with history of difficulty in breathing especially while crying and choking kind of sound when coughing. But when child was calm, quiet and asleep there are no complaints and the baby was comfortable. She was

otherwise apparently normal and active with no delay in milestones.

A pre-anaesthetic checkup was done. All routine investigations were within normal limits.

Patient was posted for removal of the lesion, after informed consent from the parents.

Course of Anaesthesia

Patient was premedicated with Inj Glycopyrrolate, Inj Midazolam and Inj Fentanyl and anaesthesia was induced with Inj Thiopentone sodium in appropriate doses with Inj Succinyl choline to facilitate intubation. However, it was difficult to ventilate the patient during the period of apnoea. On laryngoscopy, the resident was not able to visualize the larynx and intubation was unsuccessful. Second attempt of direct laryngoscopy was done and still larynx was not visualized [2]. Attempts at ventilation were only partly successful (Fig. 1).

Patient soon came out of scoline apnoea and we decided to intubate the patient under inhalational anaesthesia with halothane [4, 5] (as available).

When adequate plane of anaesthesia was reached, laryngoscopy was done and a small fleshy structure was seen obstructing more than two-third of the larynx. It was gently pushed aside using the endotracheal tube itself but it fell back into place over the larynx on shifting the endotracheal tube even slightly. Intubation was successful in the second attempt. After confirming correct placement of the ETT the patient was administered inj Atracurium in doses required. After the ETT was secured we held the fleshy mass with a Magills forceps (Fig. 2) and found it to be rather long, more like a worm and similar in diameter to the ETT in situ. It was probably arising from upper end of oesophagus (Fig. 3).

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Fig. 1 Anaesthesiologist holding polypoidal mass using Magill's forceps

Fig. 2 Surgeon holding polypoidal mass

The growth was ligated by the surgeon and sent for HPE.

The subsequent course of anaesthesia and post reversal recovery were uneventful. Post-operatively the patient did well.

Discussion

No difficulty in airway was anticipated [3] in this case. However in paediatric cases [6], even a short delay in ventilating the patient during scoline apnoea may lead to rapid oxygen desaturation with considerable fall in SPO₂ on the monitor. In this case, probably, the tip of the growth obliterated the larynx and made it difficult to mask ventilate the patient. Due to the same reason it was difficult to

Fig. 3 Polypoidal mass after excision

visualize the larynx during laryngoscopy. Keeping a cool head under such circumstances and avoiding chaos is of prime importance. Luckily return of spontaneous respiration was not delayed and we were able to maintain the patients ventilation and SPO₂ in spite of partial obstruction of larynx.

Secondly, instrument manipulation by the surgeon in the same restricted field is a cause for concern in such cases. Accidental extubation of trachea and even endobronchial intubation should be watched for very vigilantly during anaesthetic management.

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