

Case Presentation

Successful Management of Difficult Airway in an Adult Patient of Turner Syndrome

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Abstract

The inability to successfully manage a difficult airway is responsible for 600 annual deaths, 30% of which are attributable to anesthesia [1]. According to Gil, et al., 18% of patients are difficult to intubate, 5% are difficult to oxygenate and between 0.004 and 0.008% cannot be intubated or oxygenated [2].

Treating patients with genetic abnormalities is a challenge. Turner syndrome is a disease that has a prevalence of 2000 to 2500 alive, female children [3]. It is a result of partial or complete X chromosome monosomy [4]. It is not odd these patients need surgery for other causes from their genetic pathology. The present case emphasizes on the increasing difficulty of airway management on patients with Turner syndrome and the use of videolaryngoscope and tube introducer [5].

Case Presentation

A 52-years-old woman with Turner syndrome presented multiple neck and facial deformities was scheduled for laparoscopic cholecystectomy. Weight: 87kg, Height: 1.52cm BMI: 37.8 With vital signs BP: 135/84 mmHg, HR: 94 x', SpO₂ 93%, RF: 18 x' (Figures 1-4).

Labs with alteration

Induction of anesthesia was achieved with midazolam 2mg, fentanyl 250mcg, rocuronium 40mg, propofol 100mg. Videolaryngoscopy was performed with Vividtrac equipment using eschmann traqueal tube introducer. Successfully intubated in the first attempt with cuffed endotracheal tube number 7.0mm (internal diameter). Anesthesia was maintained with sevofane 2-2.5% and



Figure 1: Turner Syndrome Post eyes 01.



Figure 2: Turner Syndrome Pre eyes 01.



Figure 3: Turner Syndrome Post eyes 02.



Figure 4: Turner Syndrome Pre eyes 02.

oxygen (40%) along with fentanyl infusion. The intraoperative course was uneventful. At the end of surgical procedure, which lasted for 1h 20min, patient's trachea was successfully extubated.

Video link: https://youtu.be/8_GQzcGcNw4.

References

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