

Regarding neonates with upper airway blockage and awake endotracheal intubation.

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Abstract

Upper airway obstruction is a danger in neonates with Pierre Robin or Treacher-Collins syndrome, and surgical attachment of the tongue to the jaw may be required. Such infants are at a high risk of hypoxia during anaesthetic induction, necessitating awake fiberoptic intubation. The problem was rectified by inserting the laryngeal mask while awake. For continuous upper airway obstruction, a month-old infant with Pierre Robin syndrome and another with Treacher-Collins syndrome were scheduled for surgical fixation of the tongue to the jaw.

Keywords: Upper airway obstruction, Treacher-Collins syndrome, Hypoxia.

Introduction

Fibrotic intubation was attempted in both patients but abandoned due to frequent decreases during the attempts. The use of a laryngeal mask while awake decreased upper airway congestion and improved oxygenation. Fiberoptic intubation using the laryngeal mask was simple to do. After that, anaesthesia was administered [1]. Following the placement of the laryngeal mask, there was no hypoxia. Awake fiberoptic intubation with the laryngeal mask was also successful in two other infants with Treacher-Collins syndrome and one baby with Pierre Robin syndrome. We believe that awake insertion of the laryngeal mask can be helpful in facilitating oxygenation by relieving upper airway obstruction and facilitating fiberoptic intubation in newborns with expected endotracheal intubation of at risk of airway obstruction and wakefulness fiberoptic endotracheal tube could agglomerate hypoxia [2].

A massive risk of airway obstruction in a toddler with Pierre Robin syndrome and Treacher-Collins syndrome

This may necessitate surgically attaching the tongue to the mandible. Mask breathing and tracheal intubation can be challenging in such infants, and awake fiberoptic intubation is generally thought to be the most reliable. We present the case of two infants in whom awake fiberoptic intubation was not possible due to severe hypoxia. The problem was rectified by inserting the laryngeal mask while awake. We also describe three other newborns in whom awake fiberoptic intubation through the laryngeal mask was simple. The baby was taken to the operating room in the prone position [3].

The tracheal tube was put into the laryngeal mask after the breathing system was detached from it. The fiberscope was inserted into the tracheal tube included in the laryngeal mask and the tube was simply moved into the trachea over

the fiberscope. Anesthesia was induced with sevoflurane inhalation and neuromuscular blockade was established with vecuronium after accurate tracheal intubation was confirmed by the presence of carbon dioxide waveforms. The intubating tube was detached from the breathing apparatus, and the tube's connector was removed. The laryngeal mask was removed over these two tracheal tubes by supporting the intubated tube with the other tube [4].

The breathing equipment was reconnected and accurate tracheal intubation was reconfirmed once the connector was linked to the intubating tube. The use of a Macintosh laryngoscope revealed no section of the glottis. With the nasal airways in place, the youngster was brought to the operating room. After receiving oxygen through a facemask. Fiberoptic intubation attempts were abandoned because levels dropped as the fiberscope tip reached the back of the tongue [5]. By putting the index finger in the oropharynx, a size 1 laryngeal mask was applied and maintained in place. The mask and the finger in the mouth were tolerated by the patient. Anesthesia was induced, and neuromuscular blockade was established with vecuronium. Fiberoptic intubation *via* the laryngeal mask was simple to do. The laryngeal mask was simply removed using the method [6].

Conclusion

Intubation while the patient is awake might be stressful. Adults have often been given conscious sedation to help them relax during fiberoptic intubation. When there are malformations of the head and neck, and the pharyngeal space is constricted due to a tiny jaw and relatively wide tongue, using the fiberscope can be problematic. Second, swallowing, gagging, or sobbing can easily knock the fiberscope out of place, making it harder to locate the glottis. Third, a new-born who requires surgical tongue fixation is at an increased risk of hypoxia.

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