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Letter to Editor

Uvular injury after double lumen tube insertion: A rare cause of persistent postoperative sore throat

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Letter to Editor

D.Postoperative sore throat (POST) is a common complaint with an incidence of 24-100% [1] that occurs following placement of airway devices in patients administered general anaesthesia.

POST results in discomfort, patient dissatisfaction after surgery and leads to delay in patient's return to normal routine activities. Severe, persistent and unresolving POST may be attributed to uvula injury. We report uvular injury in a patient inspite of uneventful placement and removal of double lumen tube (DLT).

A 58-year-old male (Weight-75 kilograms, Height-172 cm, BMI-25), case of left lower lobe carcinoid tumour was posted for left lower lobe sleeve lobectomy. On preanaesthetic checkup, according to American Society of Anesthesiologists physical status (ASAPS) classification system, patient belonged to ASAPS I. The patient was fasted according to standard ASA fasting guidelines. We planned combined general anaesthesia and thoracic epidural as the anaesthetic and analgesic technique. After shifting the patient to operating room, peripheral intravenous access was obtained and all standard monitoring devices including electrocardiography, noninvasive blood pressure, and pulse oximetry were attached. After positioning patient in left lateral decubitus, painting and draping, using 18 gauge Touhy needle, T6– T7 epidural space was identified at 7.5 cm mark using loss of resistance (LOR) technique and catheter threaded upto 13 cm mark. After securing catheter and confirming negative aspiration of blood or CSF, 3 ml of 2% lignocaine with 1 in 200000 unit adrenaline was given as test dose. The patient was turned supine, preoxygenation with 100% oxygen was done. The patient was premedicated with Inj Fentanyl 160 micrograms. General anaesthesia was induced using titrated doses of Inj Propofol. Adequate bag and mask ventilation was ensured and Inj atracurium 0.5 mg/kg was administered. After completion of 3 minutes, tracheal intubation was done with direct laryngoscope (Macintosh #4) and 39 Fr Robertshaw's left sided DLT was placed. The correct position of tube was checked by auscultation and further confirmed by fibreoptic bronchoscopy. Left radial artery was cannulated. Total duration of one lung ventilation (OLV) was 4 hours 20 minutes. The overall period of OLV was uneventful as there were no episodes of desaturation and hemodynamic instability. After completion of surgical procedure, patient was turned supine, thorough suction from both lumens of DLT was done. DLT was removed and I-gel no 4 was placed.

After return of spontaneous respiratory efforts, patient was reversed and extubated. He was shited to intensive care unit (ICU) for further observation. Few hours later, he complained of foreign body sensation in throat and as if something was stuck in throat. The foreign body moved backwards during inspiration and aggravated airway obstruction. We considered it most probably as airway mucous secretions that would have accumulated due to failure to cough them out effectively. Steam inhalation, saline nebulization and chest physiotherapy was done and patient was encouraged to cough out secretions in throat. However, few hours later he again reported same complaints as there was no improvement with measures taken by us. Hence we decided to go for inspection of his pharynx and found an elongated, swollen, inflamed uvula was noted (Figure 1). We diagnosed as uvula injury caused by impingement of DLT. We reassured him and advised not to strain further as it would further aggravate uvular injury. He made complete recovery over a period of 5 days. Uvula injury after placement of endotracheal intubation [2] and laryngeal mask airway [3] has been reported earlier. The compression of uvula between hard palate and airway device has been reported as causative factor. Excessive compression can cause mechanical interruption of blood supply and result in uvular necrosis. Proper positioning of DLT to one side of midline can avoid this complication.

To conclude, uvular injury should always be kept as differential diagnosis in patient with severe persistent sore throat particularly if asso-

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ciated with foreign body like sensation. Careful and thorough examination of oropharynx should be done to confirm diagnosis. Though condition responds well to conservative management but reassurance addressing the cause and expected duration is must to reduce distress experienced by patient.

References

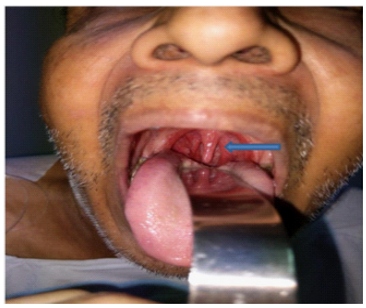

Figure 2: Arrow showing an elongated, swollen, inflamed uvula.

1. Christensen AM, Willemoes-Larsen H, Lundby L, Jakobsen KB. Postoperative throat complaints after tracheal intubation. Br J Anaesth. 1994;73:786–7.

2. Atkinson CJ, Rangasami J. Uvula necrosis-an unusual cause of severe postoperative sore throat. Br J Anaesth. 2006;97:426-7.

3. Emmett SR, Lloyd SD, Johnston MN. Uvular trauma from a laryngeal mask. Br J Anaesth. 2012;109:468–9.