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CUT THROAT INJURIES ...CHALLENGES FOR ANAESTHETIST

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ABSTRACT Cut throat injuries are regarded as fatal injuries , as there is high chances of injury to vital structures of neck like major vessels of neck ,trachea ,esophagus. Early intervention is necessaey in such cases . We hereby report a case of cut throat injury for anaesthetic management . **Introduction** : Patients with cut throat injuries presenting to emergency departments poses a serious challenges . Managing Airway in cut throat patient is very challenging for Anaesthetist . Cut throat patients may present with severe complications ,distorted anatomy ,bleeding vessels , etc . Securing a airway before exploration is challenging for Anesthestist . **Case**: Here we are presenting 20year male with suicidal cut throat under alcohol influence , with distorted tracheal anatomy ,trachea was fully exposed , patient was maintaining saturation of 94% on room air , posted for tracheostomy and primary closure of esophageal tear .

KEYWORDS :

INTRODUCTION

Cut throat injuries may lead to death of patients if not treated promptly . Patient may present with bleeing of vessels , which may lead to shock and may lead to death of patient . Airway management in cut throat patients is very challenging , Securing endotracheal tube before wound exploration and before hemostasis is more challenging .In this case endotracheal tube is secured and after that tracheostomy done by ENT surgeons and primary closure of esophageal tear done by Surgeons .

Case Presentation

A 20 year young male brought to casualty with suicidal cut throat ,under alcohol influence.

On Examination , patient was conscious oriented , maintaining saturation of 94% on room air With Pulse 100/min ; BP 110/60 mmhg , Respiratory rate 24/min .

On auscultation, bilateral air entry equal and clear . Patient immediately shifted to operation theater after laboratory investigation and blood blood products arrangement . In the operation theater patient monitored with multipara monitors , including an SPO2 probe; ECG ;blood pressure monitor .

18 G iv cannula is secured on right side of arm , Premedication including inj.glycipyrolate 0.2mg iv , inj.ondansetron 4mg iv given . IV inj tranexamic acid 1gram ,in 500 ml of Ringer lactate started . 7no .Nasal airway is inserted in left nostril and endotracheal tune connector is attached to airway and anesthesia circuit is connected . Inj fentanyl 2ug/kg ,Inj .Propofol 2mg/kg iv given along with that sevoflurane started at concentration of 2 .After confirming that patient is sedated , and relaxed , bougie guided through exposed tracheal rings and then endotracheal tube number 8mm is railroaded through bougie .Confirmation done by auscultation and tube fixed , and inj.Rocuronium 1mg/kg given iv given.

Tracheostomy done at c5-c6 level , hemostasis achieved , and primary repair of esophagus done by surgeons . Intraoperative blood loss replaced with 1pcv and 2ffp . Patient shifted on ventilatory support due to poor respiratory efforts .Patient weaned off from ventilatory support and decannulated after 15 days with good voice and ability to swallow .good voice and ability to swallow .good voice and ability to swallow .

DISCUSSION :

Cut throat injuries are usually inflicted by sharp items in this case it was done by sharp broken glass . Major vessels and vital structures course through this area may worsen the situation and may lead to dreaded complications . Investication should be done to detect the severity of injury , to know the depth of structures involved . Chest X ray AP , and lateral ; Computed tomography scan and barium swallow should be done , if the patient is vitally stable . These procedure should not delay the airway management . These patient may deteriorate even though they are stable since airway edema , hematoma may occur therefore patient should be taken immediately to operation theater . On examination wound was approx.. 9cm x 2cm in size , extending from hyoid to cricoid cartilage . No active bleeding was present . Our plan was to secure a bougie though exposed trachea and railroad the endotracheal tube , under minimal sedation with intraprocedural sevoflurane through circuit attached to nasal airway . After procedure patient shifted to ICU , and weaned off from ventilatory support and decannulated after 15 days , with good voice and ability to swallow , and patient discharged home three weeks after admission .

CONCLUSION

Airway injury is very challenging for anaesthetist . Always secure a airway should be the first priority .Immediate care and surgical repair should be done without delay .

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