

Anaesthetic Management in Temporomandibular Joint Ankylosis Using a Newer Bronchoscope-Ambu Ascope

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DESCRIPTION

Any trauma leading to haemarthrosis in temporomandibular joint may proceed to fibrosis and develop bony ankylosis. Causes of TMJ ankylosis may be congenital, trauma, infection, idiopathic and less frequently, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, fibrodysplasia ossificans, etc [1].

Challenges in securing airway

The patients with TMJ ankylosis may present with restricted or no mouth opening. Mallampatti grades of III or IV in association with limited neck movements adds difficulty. Where securing definitive airway is a challenging for the anaesthesiologist.

Choanal atresia increases difficulties in securing the airway; one may consider invasive neck approach.

Prerequisites

Patient co-operation holds upper hand in successful awake intubation. Difficult airway trolley, surgical neck access needs to be kept ready.

Premedication

Antianxiety medication like benzodiazepines, antisialogogues helps in smooth intubation.

Sedation and analgesia

Short acting opioids like fentanyl or alpha 2 agonists like dexmedetomidine can be safely used till the definitive airway is secured.

Airway anaesthesia

Awake intubation requires adequate analgesia and airway anaesthesia for the successful intubation. Nasal packing with

cotton plugs soaked in lignocaine+adrenaline. Anaesthetisation of pharyngeal and laryngeal mucosa using lignocaine 4% nebulisation. Transtracheal block for vocal cord anaesthetization [2].

Choice of airway management

The method of securing airway depends on patient condition, equipment available and the treating physician skills. Fiberoptic intubation is considered gold standard technique² in such scenario. With limited mouth opening nasal intubation is the technique of choice, but choanal atresia (if membranous) requires serial dilatation using nasogastric tubes and smaller size endotracheal tubes.

When passing preloaded ETT over scope is difficult from one nostril, ETT and scopes can be passed from different nostril. Under scopic vision ETT can be passed into trachea.

Extubation

While extubation patients with difficult airway ensure that adequate neuromuscular blockage is reversed, patient is fully awake, vocal cord movements are present and patient is breathing adequately. Extubation over airway exchange catheter or fiberoptic scope may prevent untoward loss of airway if anticipated.

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