

Obstruction of Endotracheal Intubation by a Mobile Pedunculated Polyp

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Congenital or acquired abnormalities of the oropharynx and upper respiratory tract may lead to difficult problems in endotracheal intubation and airway management.

REPORT OF A CASE

A 53-year-old man was scheduled for mediastinoscopy for evaluation of a mass in the left lung. Bronchoscopy two weeks prior to admission had disclosed no abnormality, but fiberoptic bronchoscopy two days prior to operation revealed a mucosal polyp, 3-5 mm in diameter, on the left upper glottic fold. Following adequate premedication and induction of anesthesia with halothane an attempt was made to pass an oral endotracheal tube. The epiglottis was displaced posteriorly to obstruct the view of the vocal cords by a pedunculated mucosal polyp, 10 mm in diameter, located anterior to the epiglottis (fig. 1a). The polyp was displaced posteriorly, partially obstructing the vocal cords (fig. 1b). The endotracheal tube was placed successfully by moving the polyp to the left with the tip of the tube. At the completion of anesthesia the trachea was extubated and the patient did not experience any problem of airway obstruction.

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Benign cysts and tumors of larynx and pharynx are relatively rare. Lipomas may occur as a yellow, pedunculated mass, usually arising from the posterior lateral wall. Neurolemmoma, neurofibroma, amyloid tumors, or granuloma-cell myoblastoma may rise from the aryepiglottic folds.^{1,2} Sigurbjornsson reported two cases of airway obstruction resulting from upper airway tumors. Thomas⁴ reported a case of impaction of the epiglottis following extubation. A case of obstruction to oroendotracheal intubation by a pedunculated polyp has not been reported, and is presented as an unusual and interesting event.

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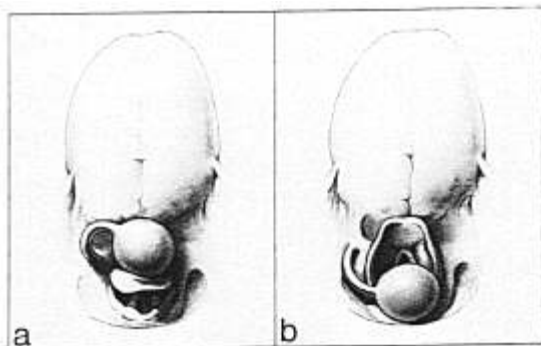


FIG. 1a, pedunculated polyp displacing the epiglottis posteriorly to partially obstruct the view of the vocal cords; b, the polyp has moved posterior to epiglottis and is partially obstructing the vocal cords.