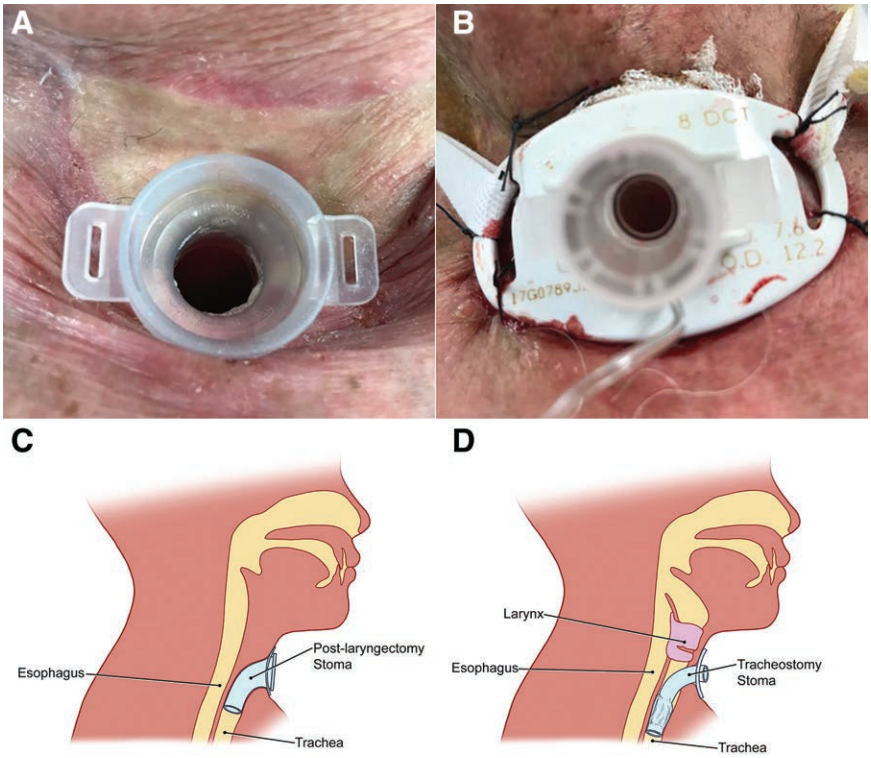
Postlaryngectomy Stoma *versus* Tracheostomy

Implications for Perioperative Airway Management

Angela T. Truong, M.D., Dam-Thuy Truong, M.D.



Patients with a postlaryngectomy stoma present important and often unrecognized implications for perioperative airway management. Because of its appearance and location, the stoma (*A*) is often mistaken for a tracheostomy (*B*). A tracheostomy is a surgical opening to access the tracheal lumen with the entire larynx remaining intact (*D*). In contrast, after total laryngectomy, the trachea is brought to the skin as a stoma, which no longer has any anatomical connection with the oropharyngeal cavity and digestive tract (*C*). Consequently, it is impossible to deliver oxygen to the lungs with nasal cannula, face mask, or bag-mask ventilation. Attempts to intubate the trachea from above the stoma *via* the oral or nasal route will be unsuccessful. Similarly, because pulmonary aspiration of gastric contents cannot occur, these patients do not need to be kept *nil per os* for surgery.[1] Conversely, the risk of foreign body aspiration is significant because of the direct communication of the stoma with its surroundings.[2] Care must be taken when handling small objects such as syringe covers near an uncovered stoma.

To enable intraoperative positive pressure ventilation, it is necessary to insert a cuffed tracheal tube into the stoma. In contrast to the dangers of changing a fresh tracheostomy tube to a tracheal tube,[3] tube placement into the laryngectomy stoma is usually straightforward. In patients with a tracheoesophageal voice prosthesis, however, caution should be exercised to prevent its dislodgement into the lungs. Finally, because the distance from the stoma to the carina is relatively short, endobronchial intubation may occur.

Acknowledgments

The authors acknowledge David M. Aten, M.A., C.M.I., Senior Medical Illustrator, M.D. Anderson Cancer Center, Houston, Texas, for his help in creating the illustrations (C and D) that accompany this article.

Competing Interests

The authors declare no competing interests.

From the Department of Anesthesiology and Perioperative Medicine, University of Texas, M.D. Anderson Cancer Center, Houston, Texas.

Correspondence

Address correspondence to Dr. A. Truong: atruong@mdanderson.org

References

1. Truong AT, Truong DT, Gillenwater AM, Rozner MA: Gastric aspiration in patients with a laryngectomy stoma: Is it possible? J Clin Anesth 2006; 18:557–8
2. Nwiloh J, Fortson J: Aspirated foreign body in a laryngectomized patient: Case report and literature review. Ear Nose Throat J 2001; 80:744–6, 748
3. Patiño MA, Truong DT, Truong A, Cata JP: Do not burn your airway bridge: A technique to safely exchange a tracheostomy tube for a tracheal tube. A A Case Rep 2016; 7:155–7

ANESTHESIOLOGY REFLECTIONS FROM THE WOOD LIBRARY-MUSEUM

Not Electric, Not Eclectic, But Eclectic Oil and Dr. Thomas's "Trial by Jury"

One of the stranger annals of pain management involved "Eclectric Oil." Although advertisements for this nostrum appeared as early as 1858, the name of New York's Dr. S. N. Thomas (*upper left* and *right*) was associated with the oil by 1876. Americans' fascination with electricity and their romance with back-to-nature versions of medical practice resulted in a portmanteau of "electric" + "eclectic," yielding "eclectric." Eclectric Oil was an eclectic combination of alcohol, chloroform, camphor, and balsam fir with the tinctures of opium, guaiac, and catechu, as well as the oils of checkerberry, oregano, sassafras, hemlock, and turpentine. Formulated to be taken internally or externally by man or beast, Eclectric Oil was hailed for its "magical pain-killing and healing properties." According to smaller print in the advertising (*lower left*) on the back of some trade cards, this panacea's reputation was not "settled by a jury of twelve, but by thousands of intelligent, thinking people…."

George S. Bause, M.D., M.P.H., Honorary Curator and Laureate of the History of Anesthesia, Wood Library-Museum of Anesthesiology, Schaumburg, Illinois, and Clinical Associate Professor, Case Western Reserve University, Cleveland, Ohio. UJYC@aol.com.