

Emergency Airway Management with a Laryngeal Mask Airway in a Patient with Massive Cervical Lipomas

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Cervical lipomas can cause significant respiratory compromise and create challenges during airway management. The American Society of Anesthesiology difficult airway algorithm recommends insertion of a laryngeal mask airway for patients that have failed mask ventilation or conventional intubation. However, in patients with massive cervical lipomas, bypassing direct laryngoscopy and inserting a laryngeal mask airway may be necessary to more rapidly improve oxygenation and ventilation.

These images show a patient with circumferential neck lipomas who developed hypoxic respiratory failure due to congestive heart failure. On airway examination, the patient had a short thyromental distance, severely limited neck range of motion and unknown Mallampati score due to altered mental status. Placing the patient in the “sniffing” position was impossible due to the massive neck lesions. In addition, the patient likely had redundant pharyngeal tissue collapsing the supraglottic airway, making video laryngoscopy potentially difficult. In patients with these findings, mask ventilation and laryngoscopy should be waived. The initial airway intervention should be laryngeal mask airway placement.¹ Further steps to secure a definitive airway can be attempted once ventilation is confirmed.²

In the event that laryngeal mask airway placement is unsuccessful in patients with distorted cervical anatomy, bedside cricothyrotomy or tracheostomy would be required.

Should surgical interventions fail, we would suggest emergent cannulation for extracorporeal membrane oxygenation.

Initial laryngeal mask airway insertion in patients with distorted cervical anatomy provides a quick means for ventilation and minimizes soft tissue damage and swelling while a definitive airway can be secured.

Competing Interests

The authors declare no competing interests.

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