A 52-YR-OLD woman with a history of alcohol abuse and polycystic liver disease presented for an urgent orthotopic liver transplant. She had recurrent ascites, muscle wasting, jaundice, pancytopenia, marked coagulopathy, and a bilirubin count of 303 μM (18 mg/dl). The patient was fasted and no problems were anticipated with ventilation or laryngoscopy. After the implementation of routine and invasive monitors, general anesthesia was induced with fentanyl, propofol, and rocuronium. Elective GlideScope laryngoscopy (Verathon, Bothell, WA) was performed and recorded using a GlideScope® Cobalt #3 blade (Verathon, Bothell, WA). Laryngoscopy and intubation were easily accomplished. Upon subsequent review of the laryngoscopy recording, it was apparent that the vocal cords were clearly icteric. Tissue staining by bilirubin is frequently noted; however, the author is unaware of any reports of icteric vocal cords. Indeed, this was not apparent until the laryngoscopy was subsequently reviewed. It is possible that many subtleties are overlooked as we focus on quickly securing the airway (or the completion of other time-sensitive procedures). Although the diagnosis of jaundice did not require laryngoscopic confirmation, it is likely and probable that subsequent review of recorded images, unhurried by physiologic and workflow pressures, will provide us with additional insights and opportunities to refine our techniques. The educational benefits of video laryngoscopy have emphasized the value of real-time meaningful feedback.1–3 It is the author’s impression that there may be even greater educational value derived from video playback at a time and pace more conducive to real learning.

The image is somewhat tinted but un-retouched. This model monitor (AVL; Verathon, Bothell, WA) has white balance and color tone as factory presets.

References