Airway Injury during Anesthesia
A Closed Claims Analysis
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Background: Airway injury during general anesthesia is a significant source of morbidity for patients and a source of liability for anesthesiologists. To identify recurrent patterns of injury, the authors analyzed claims for airway injury in the American Society of Anesthesiologists (ASA) Closed Claims Project database.

Methods: The ASA Closed Claims database is a standardized collection of case summaries derived from professional liability insurance companies closed claims files. All claims for airway injury were reviewed in depth and were compared to other claims during general anesthesia.

Results: Approximately 6% (266) of 4,460 claims in the database were for airway injury. The most frequent sites of injury were the larynx (33%), pharynx (19%), and esophagus (18%). Injuries to the esophagus and trachea were more frequently associated with difficult intubation. Injuries to temporomandibular joint and the larynx were more frequently associated with nondifficult intubation. Injuries to the esophagus were more severe and resulted in a higher payment to the plaintiff than claims for other sites of airway injury. Difficult intubation (odds ratio = 4.53, 95% confidence interval [CI] = 2.36, 8.71), age older than 60 yr (odds ratio = 2.97, 95% CI = 1.51, 5.87), and female gender (odds ratio = 2.43, 95% CI = 1.09, 5.42) were associated with claims for pharyngoesophageal perforation. Early signs of perforation, e.g., pneumothorax and subcutaneous emphysema, were present in only 51% of perforation claims, whereas late sequelae, e.g., retropharyngeal abscess and mediastinitis, occurred in 65%.

Conclusion: Patients in whom tracheal intubation has been difficult should be observed for and told to watch for the development of symptoms and signs of retropharyngeal abscess, mediastinitis, or both. (Key words: Esophageal perforation; liability; mediastinitis; mediolateral; pharyngeal perforation; temporomandibular joint disorders; vocal cord injuries.)

INJURIES to the airway are a well-recognized complication of anesthesia.1–16 In 1991, we briefly described the sites of injury and standard of care in 97 claims for airway trauma in a review of adverse respiratory events in the American Society of Anesthesiologists (ASA) Closed Claims database.17 The most frequent sites of airway injuries were the larynx, pharynx, and esophagus. Forty-two percent of the claims for airway injuries were associated with difficult intubation.17 Since this early report, additional claims for airway injuries, which contain more in-depth information, have been entered into the Closed Claims database. The purpose of this study was to identify patient and anesthetic factors associated with the specific sites of airway injuries and to describe the associated features of liability.

Materials and Methods

The ASA Closed Claims Project is a structured evaluation of adverse anesthetic outcomes obtained from the closed claim files of 35 US professional liability insurance companies. Claims for dental damage are not included in the database. The current study was based on a total of 4,460 claims for adverse outcomes that occurred between 1961 and 1996. Sixty-eight percent of the injuries leading to claims occurred between 1980 and 1990.

The data collection process previously has been described in detail.18 Briefly, a closed claim file, typically consisting of relevant hospital and medical records, nar-
Overview

Of 4,460 claims in the database, 266 claims (6%) were for airway injury. Compared with 2,874 other claims involving general anesthesia, a higher proportion of airway injury claims involved females, elective surgery, and outpatient procedures, and a lower proportion of airway injury claims involved children (table 1). Difficult intu-
Injury was a factor in 39% of airway injury claims (103 of 266 claims), compared with 9% of other general anesthesia claims (251 of 2,874 claims, $P < 0.001$, table 1). Both the frequency of payment and the amount of payment were less in claims for airway injury compared with other injuries during general anesthesia ($P < 0.001$, table 2). The median payment to the plaintiff was $26,250 for airway injury claims, compared with $125,000 for other injuries during general anesthesia (table 2).

### Specific Sites of Injuries

The most frequent sites of injury were the larynx (n = 87, 33% of airway injury claims), pharynx (n = 51, 19%), esophagus (n = 48, 18%), and the trachea (n = 39, 15%) (table 3).

**Laryngeal Injuries.** The most common types of laryngeal injury included vocal cord paralysis (n = 30, 34% of laryngeal injury claims), granuloma (n = 15, 17%), arytenoid dislocation (n = 7, 8%), and hematoma (n = 3, 3%). Although 80% of laryngeal injuries were associated with routine (nondifficult) tracheal intubation (table 3), intubation was reported to be difficult in more than a quarter of claims for granuloma (n = 4 of 15), arytenoid dislocation (n = 2 of 7), or an unclear cause of hoarseness (n = 7 of 17). Most (85%) of the laryngeal injuries were associated with short-term tracheal intubation because prolonged tracheal intubation (5 h or more postoperatively) occurred in only 15% (n = 13) of the claims. The frequency of payment and the median payment for laryngeal injury ($20,000; table 4) did not differ significantly with specific sites of laryngeal injury.

### Table 1. Demographic Characteristics for Patients Filing Claims for Airway Injury

<table>
<thead>
<tr>
<th>Gender</th>
<th>Airway Injury [n = 266] [n (%)]*</th>
<th>Other General Anesthesia Claims [n = 2,874] [n (%)]*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>181 (69%)††</td>
<td>1,592 (56%)††</td>
</tr>
<tr>
<td>Male</td>
<td>81 (31%)††</td>
<td>1,255 (44%)††</td>
</tr>
<tr>
<td>ASA Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I–II</td>
<td>123 (73%)†</td>
<td>1,272 (67%)†</td>
</tr>
<tr>
<td>III–V</td>
<td>45 (27%)†</td>
<td>634 (33%)†</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric (≤16 yr)</td>
<td>11 (4%)††</td>
<td>385 (14%)††</td>
</tr>
<tr>
<td>Adult (&gt;16 yr)</td>
<td>240 (96%)††</td>
<td>2,340 (86%)††</td>
</tr>
<tr>
<td>Obese</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>48 (41%)†</td>
<td>454 (34%)†</td>
</tr>
<tr>
<td>No</td>
<td>69 (59%)†</td>
<td>596 (66%)†</td>
</tr>
<tr>
<td>Emergency surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31 (17%)‡‡</td>
<td>527 (26%)‡‡</td>
</tr>
<tr>
<td>No</td>
<td>149 (83%)‡‡</td>
<td>1,523 (74%)‡‡</td>
</tr>
<tr>
<td>Procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>127 (73%)‡‡</td>
<td>1,449 (82%)‡‡</td>
</tr>
<tr>
<td>Outpatient</td>
<td>48 (27%)‡‡</td>
<td>325 (18%)‡‡</td>
</tr>
<tr>
<td>Difficult intubation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>103 (39%)††</td>
<td>251 (9%)††</td>
</tr>
<tr>
<td>No</td>
<td>163 (61%)††</td>
<td>2,623 (91%)††</td>
</tr>
</tbody>
</table>

* The percentage is based on claims without missing data.
† $P < 0.001$ airway injury versus other general anesthesia claims.
‡ $P < 0.01$ airway injury versus other general anesthesia claims.
ASA = American Society of Anesthesiologists.

### Table 2. Severity of Injury, Standard of Care, and Claim Payment for Airway Injury versus Claims for Other Injuries during General Anesthesia

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Nondisabling (score = 0–5) [n (%)]*</th>
<th>Disabling (score = 6–8) [n (%)]*</th>
<th>Death (score = 9) [n (%)]*</th>
<th>Standard [n (%)]*</th>
<th>Substandard [n (%)]*</th>
<th>Yes [n (%)]*</th>
<th>Median Amount ($)</th>
<th>Range ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway injury</td>
<td>231 (87%)‡‡</td>
<td>13 (5%)‡‡</td>
<td>21 (8%)‡‡</td>
<td>180 (79%)‡‡</td>
<td>47 (21%)‡‡</td>
<td>128 (54%)‡‡</td>
<td>$26,250‡‡</td>
<td>$15–$1,150,000‡‡</td>
</tr>
<tr>
<td>Other general anesthesia claims</td>
<td>1,134 (40%)‡‡</td>
<td>582 (20%)‡‡</td>
<td>1,152 (40%)‡‡</td>
<td>1,142 (46%)‡‡</td>
<td>1,321 (54%)‡‡</td>
<td>1,739 (66%)‡‡</td>
<td>$125,000‡‡</td>
<td>$25–$23,200,00‡‡</td>
</tr>
</tbody>
</table>

* The percentage is based on claims without missing data.
† These data represent claims where standard of care could be judged. The remainder were impossible to judge.
‡ $P < 0.001$ airway injury versus other general anesthesia claims.

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Pharyngeal Injuries. Claims of pharyngeal injuries included pharyngeal perforation (n = 19, 37% of pharyngeal injuries), lacerations and contusions (n = 16, 31%), localized infection (n = 6, 12%), sore throat without physical evidence of injury (n = 6, 12%), and miscellaneous injuries (n = 4, 8%; i.e., foreign body, burn, hematoma, diminished taste sensation). Half (n = 26, 51%) of all pharyngeal injuries and 68% of pharyngeal perforations were associated with difficult tracheal intubation. Pharyngeal perforations that occurred during nondifficult intubation were attributed to a nasogastric tube (n = 1), a suction catheter (n = 1), jet ventilation (n = 1), and an unclear mechanism of injury (n = 3). The severity of injury, standard of care, frequency of payment, and amount of payment for all types of pharyngeal injuries were similar to all other sites of airway injuries combined (table 4). However, when compared to other types of pharyngeal injuries, pharyngeal perforation was associated with a greater severity of injury (P = 0.001), a greater proportion of substandard care (P = 0.029), and a higher payment to plaintiff (median payment = $80,000 for pharyngeal perforation vs. $2,750 for other pharyngeal injury, P < 0.001). All deaths in the pharyngeal injury claims (n = 5) occurred with pharyngeal perforation and were related to the development of mediastinitis.

Esophageal Injuries. Most claims for esophageal injuries were for esophageal perforation (n = 43 of 48 esophageal injuries, 90%). Sixty-two percent (n = 30) of all esophageal injuries were associated with difficult intubation (P < 0.001 compared with all other sites combined, table 3). In addition, esophageal injuries involved a significantly greater proportion of females (P < 0.001) and patients older than 60 yr of age (P < 0.001) compared with other sites combined (table 3). Esophageal perforation involved difficult intubation in 67% (n = 29) of claims. Most claims for esophageal perforation in which intubation was rated nondifficult (n = 14) in-

<table>
<thead>
<tr>
<th>Site of Injury</th>
<th>Nondeath [n (%)]</th>
<th>Death [n (%)]</th>
<th>Standard [n (%)]</th>
<th>Substandard [n (%)]</th>
<th>Yes [n (%)]*</th>
<th>Median ($)</th>
<th>Range ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Larynx (n = 87)</td>
<td>86 (99)§</td>
<td>1 (1)§</td>
<td>74 (96)‡</td>
<td>3 (4)‡</td>
<td>33 (43)</td>
<td>20,000§</td>
<td>853–900,000§</td>
</tr>
<tr>
<td>Pharynx (n = 51)</td>
<td>46 (90)</td>
<td>5 (10)</td>
<td>29 (71)</td>
<td>12 (29)</td>
<td>29 (64)</td>
<td>35,000</td>
<td>112–1,150,000</td>
</tr>
<tr>
<td>Esophagus (n = 48)</td>
<td>39 (81)§</td>
<td>9 (19)§</td>
<td>25 (60)§</td>
<td>17 (40)§</td>
<td>31 (69)</td>
<td>138,975‡</td>
<td>1,000–750,000‡</td>
</tr>
<tr>
<td>Trachea (n = 39)</td>
<td>33 (85)</td>
<td>6 (15)</td>
<td>20 (63)</td>
<td>12 (38)</td>
<td>20 (56)</td>
<td>23,750</td>
<td>390–450,000</td>
</tr>
<tr>
<td>TMJ (n = 27)</td>
<td>27 (100)</td>
<td>0</td>
<td>21 (100)§</td>
<td>0 (0)§</td>
<td>7 (30)</td>
<td>10,000</td>
<td>750–500,000</td>
</tr>
<tr>
<td>Nose (n = 13)</td>
<td>13 (100)</td>
<td>0</td>
<td>11 (85)</td>
<td>2 (15)</td>
<td>8 (62)</td>
<td>4,125</td>
<td>15–50,000</td>
</tr>
</tbody>
</table>

* The percentage is based on claims without missing data.
† These data represent claims where standard of care could be judged. The remainder were impossible to judge.
‡ P < 0.001 versus all other sites combined.
§ P < 0.01 versus all other sites combined.
∥ Injuries to nose not tested statistically due to small number.
TMJ = temporomandibular joint.

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infectious sequelae (mediastinitis or mediastinal abscess, retropharyngeal abscess, or pneumonia) developed in 65% of the patients (table 6). Delay in diagnosis was associated significantly with the development of the late infectious sequelae ($P < 0.001$).

**Tracheal Injuries.** The 39 claims for tracheal injury involved injury from the creation of a surgical tracheotomy ($n = 25, 64\%$), tracheal perforation ($n = 13, 33\%$), and infection ($n = 1, 3\%$). Most ($n = 21, 84\%$) of the tracheotomies were performed for the purpose of emergency airway management associated with difficult tracheal intubation. The remainder of tracheotomies ($n = 4, 16\%$) were necessary because of the development of subglottic or tracheal stenosis as a consequence of tracheal intubation. One patient died of a surgical complication of tracheotomy (unrecognized transection of the trachea).

Most claims for tracheal perforation ($9 of 13, 69\%$) involved routine (nondifficult) tracheal intubation. Perforation of the trachea became clinically evident by the development of subcutaneous emphysema ($n = 10$) and/or pneumothorax ($n = 4$), whereas the perforation was evident only on a postoperative chest radiograph (pneumomediastinum) in three patients. The perforation was diagnosed intraoperatively in only five patients, with diagnosis made in the postanesthesia care unit in four patients and postoperatively in four patients. Payment was made in 56% of the claims for tracheal injury, with a median payment of $23,750, similar to other airway injuries claims combined ($P < 0.001$, table 4). Payment did not differ with type of tracheal injury.

**Temporomandibular Joint Injuries.** Temporomandibular joint injuries accounted for 10% of airway trauma claims ($27 of 266 claims$) and were associated with routine tracheal intubation in all cases ($P < 0.004$). Sixteen of the claims were for TMJ pain and 11 were for TMJ dislocation. Preexisting TMJ disease was documented in 8 (30%) of the 27 TMJ claim files. Comparing type of injury (TMJ pain vs. dislocation), the frequency of payment was greater for TMJ dislocation than for TMJ pain ($P < 0.001$). Payment was received in 70% of the dislocated TMJ claims but in none of the claims for TMJ pain.

**Discussion**

Claims for airway injuries were relatively frequent (6%) in the ASA Closed Claims database, ranking behind three
other major types of injury: death (32%), spinal cord or peripheral nerve damage (16%), and brain damage (12%). Although most claims for airway injuries involve a low severity of injury and low payment to the plaintiff, pharyngoesophageal perforation was a serious injury, which frequently resulted in late infectious complications and death. Factors associated with claims for pharyngoesophageal perforation included difficult intubation, age older than 60 yr, and female gender.

**Methodological Issues**

Before interpreting the data, it should be emphasized that closed claims analysis has a number of previously described weaknesses. These limitations include the inability to provide numerical estimates of risk because of the lack of denominator data, the absence of rigorous comparison groups, a probable bias toward adverse outcomes, and partial reliance on data from direct participants rather than impartial observers. They spanned a period of time during which practice patterns changed. The analysis also only evaluated the information in the database that was transcribed to the data sheet by the reviewer, who depended on the information contained in the insurance company file. Specific detailed information regarding signs and mechanism of injury may therefore be incomplete compared to a prospective study. The retrospective case review studies included in the database were also selected in a nonrandom fashion, without control over geographic balance.

The logistic regression analysis compared patient and anesthetic variables associated with claims for pharyngoesophageal perforation with other airway injury claims. The usual investigation of risk factors compares patients in whom a specific adverse outcome develops (e.g., pharyngoesophageal perforation) with patients in whom the specific outcome does not develop. Because the Closed Claims Project only involves a select group of patients who file malpractice claims, the associated factors reported represent a risk for a claim for pharyngoesophageal perforation compared with a claim for another airway injury. The associated factors, therefore, are not necessarily risk factors important in the cause of pharyngoesophageal perforation.

**Pharyngoesophageal Perforation**

Although numerous case reports have been published, including reports during routine anesthesia care, pharyngoesophageal perforation remains an underappreciated complication of tracheal intubation. Perforation of the pharynx or esophagus is a serious, life-threatening injury. In the Closed Claims database, 14 of 62 (23%) patients filing claims for pharyngoesophageal perforation died. In addition, a higher payment was made than for other airway injuries, with a median payment of $80,000 for pharyngeal perforation and $138,975 for esophageal perforation.

The Closed Claims data show that difficult intubation, age older than 60 yr, and female gender increased the relative frequency of claims for esophageal or pharyngeal perforation compared with claims for other airway injuries (table 5). Difficult intubation, emergency intubation, and intubation by inexperienced personnel have been described in the literature as risk factors for pharyngoesophageal perforation. Other risk factors mentioned in case reports as potentially associated with perforation include variables

**Table 6. Clinical Signs of Perforation of Pharynx or Esophagus***

<table>
<thead>
<tr>
<th>Clinical Signs</th>
<th>Pharynx (n = 17) [n [%]]</th>
<th>Esophagus (n = 36) [n [%]]</th>
<th>Combined (n = 53) [n [%]]</th>
</tr>
</thead>
<tbody>
<tr>
<td>No early signs</td>
<td>11 (65)</td>
<td>15 (42)</td>
<td>26 (49)</td>
</tr>
<tr>
<td>Early signs</td>
<td>6 (35)</td>
<td>21 (58)</td>
<td>27 (51)</td>
</tr>
<tr>
<td>Subcutaneous emphysema</td>
<td>5 (29)</td>
<td>15 (42)</td>
<td>29 (38)</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>3 (18)</td>
<td>13 (36)</td>
<td>16 (30)</td>
</tr>
<tr>
<td>Chest x-ray only</td>
<td>0 (0)</td>
<td>1 (3)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Late sequelae†</td>
<td>13 (81)</td>
<td>21 (58)</td>
<td>34 (65)</td>
</tr>
<tr>
<td>Mediastinitis</td>
<td>7 (44)</td>
<td>18 (50)</td>
<td>25 (48)</td>
</tr>
<tr>
<td>Retropharyngeal abscess</td>
<td>8 (50)</td>
<td>4 (11)</td>
<td>12 (23)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1 (6)</td>
<td>1 (3)</td>
<td>2 (4)</td>
</tr>
</tbody>
</table>

* Based upon claims with sufficient information. Two claims for pharyngeal perforation and seven claims for esophageal perforation did not contain information on the presence or absence of early signs. One additional claim for pharyngeal perforation did not have sufficient information on late sequelae for analysis.
† Based on 16 claims for pharyngeal perforation and 36 claims for esophageal perforation.
that contribute to difficult intubation (e.g., obesity, cervical arthritis, improper head positioning, poor muscle relaxation, and haste), application of a cricoid pressure, long-term indwelling nasogastric tube, a rigid or flexible stylet (even without exposure of the tip), and the rigid bevel of an endotracheal tube. Claims in the Closed Claims database for which tracheal intubation was judged as nondifficult involved instrumentation of the pharynx or esophagus. Esophageal perforation has also been described in the literature as a complication of orogastric or nasogastric tube insertion and transesophageal echocardiography. The independent association of pharyngoesophageal perforation with advanced age and female gender found in our study has not been previously reported. The mechanism for the possible increased risk of injury in elderly women is unknown and deserves further study.

The Closed Claims data suggest that prompt diagnosis of pharyngoesophageal perforation may be difficult. Perforation has been previously reported to occur at the pyriform sinus, the hypopharynx posterior to the cricopharyngeal muscle, and the posterior wall of the cervical esophagus. Air may dissect along cervical fascial planes and lead to subcutaneous emphysema, pneumomediastinum, or a pneumothorax. Early symptoms of perforation are relatively nonspecific and include sore throat, deep cervical pain, chest pain, and cough. Later symptoms include fever, dysphagia, and dyspnea as bacterial invasion results in the delayed development of deep cervical or retropharyngeal abscess, mediastinitis, or pneumonia. In the Closed Claims database, early signs of a perforation were absent in half of the cases, and the intubation was believed by the anesthesiologist to be atraumatic. A delay in diagnosis was significantly associated with the development of late infectious sequelae in the Closed Claims database. Consequently, a delay in diagnosis may exacerbate patient morbidity and mortality. Survival after esophageal perforation has been reported to be improved by early diagnosis and initiation of treatment within 24 h. However, overall mortality after esophageal perforation was reported to be high (25%), even with rapid diagnosis and treatment, including limitation of oral intake, administration of antibiotics, and surgical closure and drainage.

The clinical implication of the Closed Claims findings is that patients in whom tracheal intubation has been difficult should be observed and told to watch for the development of symptoms and signs of retropharyngeal abscess, mediastinitis, or both. Symptoms such as severe sore throat, deep cervical or chest pain, and fever should be thoroughly investigated after difficult tracheal intubation or difficult insertion of a nasogastric tube. Surgeons should also be alerted to the possibility of such a complication after a difficult intubation, so they can respond appropriately if the patient contacts them initially.

Laryngeal and Tracheal Injuries

Claims for laryngeal injuries represented one third of the claims (n = 87) for airway injury in the Closed Claims database. Most claims for laryngeal injury occurred with routine tracheal intubation. Most cases of laryngeal damage have been reported to be caused by abrasion of the mucosa by movement of the endotracheal tube and pressure necrosis of the posterior laryngeal mucosa by the endotracheal tube. Only a minority of claims (15%) for laryngeal injury in the Closed Claims database involved prolonged tracheal intubation. However, laryngeal injury after prolonged intubation may result in a claim against a pulmonologist or another nonanesthesia physician caring for the patient.

Most (64%) of the tracheal injuries involved creation of a surgical tracheotomy. The tracheotomy was performed for the purpose of emergency airway management in the majority of these claims. Although the severity of injury was low, a lower proportion of these claims were judged to represent standard care compared with most other airway injury claims.

One third of the claims for tracheal injury were for tracheal perforation (n = 13), a rare, but severe injury. Most of the claims for tracheal perforation involved routine tracheal intubation and appropriate anesthesia care. However, the severity of injury was high, with tracheal perforation contributing to five of the six deaths in the tracheal injury group. Although the classic sign of tracheal injury is the acute development of subcutaneous emphysema or pneumothorax, or both, delayed presentation in the postanesthesia care unit or postoperatively was noted in 8 of 13 of the claims for tracheal perforation. Three cases were detected only by postoperative chest radiography taken to investigate chest pain and other nonspecific respiratory complaints. These findings are consistent with two recent case reports, which emphasize that a delayed presentation of tracheal perforation may occur more commonly than appreciated.

Temporomandibular Joint Injuries

The preponderance of claims for TMJ injuries submitted by young women is consistent with the known
The epidemiology of temporomandibular disorders. TMJ pain occurs in 10% of the population and is twice as common in women as in men.\(^3^8\) It is a disorder of primarily young and middle adulthood, and it is rare in children and the elderly. The consistent epidemiologic profile of the TMJ claims and their association with routine tracheal intubation suggest that most TMJ injuries that occur during anesthesia are secondary to underlying temporomandibular disorders. The relatively small number of claims compared to the high incidence of temporomandibular disorders within the population may be caused by a reluctance to pursue claims with expected low financial compensation. None of the claims for TMJ pain in the database received any payment and the median payment of claims for TMJ dislocation was only $10,000. Huycke and Huycke\(^3^9\) reported that plaintiff’s attorneys are unlikely to pursue claims with an estimated financial recovery for damage of less than $50,000.

In summary, claims for airway injuries are frequent in the closed claims database. Although most claims for airway injuries involve a low severity of injury and low payment to the plaintiff, pharyngoesophageal perforation may result in death because of severe infection from mediastinitis. A high index of suspicion by the anesthesiologist and the surgeon may reduce the risk of severe complications.

The authors thank Lynn Hubbard-Hamacher for her expert secretarial assistance, Pauline Cooper, B.A., and John Campos, M.A. for technical assistance. The authors also thank the members of the American Society of Anesthesiologists who served as reviewers for the Closed Claims Project. A list of reviewers is available from the authors. The following 28 organizations gave permission for acknowledgment as a source of closed claims: Anesthesia Services Medical Group, Inc., San Diego, California; Anesthesiologists Professional Assurance Trust, Miami Beach, Florida; Armed Forces Institute of Pathology, Silver Spring, Maryland; Risk Management Foundation, Cambridge, Massachusetts; COPIC Insurance Company, Denver, Colorado; The Doctors’ Company, Napa, California; Daughters of Charity National Health Systems, St. Louis, Missouri; Illinois State Medical Inter-Insurance Exchange, Chicago, Illinois; Medical Professional Insurance Association, Boston, Massachusetts; Medical Association of Georgia Mutual Insurance Company, Atlanta, Georgia; Medical Inter-Insurance Exchange of New Jersey, Lawrenceville, New Jersey; Medical Liability Mutual Insurance Company, New York, New York; Medical Mutual Insurance Company of Maine, Portland, Maine; Midwest Medical Insurance Company, Minneapolis, Minnesota; Mutual Insurance Company of Arizona, Phoenix, Arizona; National Capital Reciprocal Insurance Company, Washington, DC; NORCAL Mutual Insurance Company, San Francisco, California; Pennsylvania Medical Society Liability Insurance Company, Harrisburg, Pennsylvania; PHICO Society Liability Insurance Company, Mechanicsburg, Pennsylvania; Physicians Insurance Company of Wisconsin, Madison, Wisconsin; PIE Mutual Insurance Company, Cleveland, Ohio; Preferred Physicians Mutual Risk Retention Group, Mission, Kansas; St. Paul Fire and Marine Insurance Company, St. Paul, Minnesota; State Volunteer Mutual Insurance Company, Brentwood, Tennessee; University of Texas Medical System, Austin, Texas; Utah Medical Insurance Association, Salt Lake City, Utah; Veterans Administration, Washington, DC; and Washington State Physicians Insurance Exchange Association, Seattle, Washington.

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Anesthesiology, V 91, No 6, Dec 1999
AIRWAY INJURY DURING ANESTHESIA


Anesthesiology, V 91, No 6, Dec 1999