Foreign Body Aspiration during Fiberoptic-assisted Intubation

To the Editor:—The fiberoptic bronchoscope (FOB) has been shown to be a valuable aid in performing difficult intubations.1,2 We wish to report a potentially serious complication arising from the use of this instrument in conjunction with a ported mask (fig. 1) as described by Rogers and Benumof.3

Following induction of anesthesia and while maintaining positive pressure ventilation, the tip of an Olympus FOB was passed through the diaphragm (Anesthesia Associates, San Marcos, California) of the endoscopy port of an anesthesia mask and into the trachea. A nonlubricated #8 endotracheal tube (ETT) then was advanced easily into the trachea over the FOB. When the mask and FOB were removed, a 14 mm circular defect was noted in the center of the diaphragm. Inspection of the mask, oral airway, oral cavity, and ETT failed to reveal the missing portion of the diaphragm. Laryngoscopy was performed with a #3 Macintosh blade and the diaphragm fragment (fig. 2) retrieved from the posterior pharynx with Magill forceps. The patient was successfully reintubated, and the remainder of the anesthetic was uneventful.

Iatrogenic introduction of a foreign body into a patient’s airway can be a life-threatening complication. In this instance, the small size and translucent nature of the foreign body made visualization and retrieval more difficult. We wish to emphasize the importance of lubricating the ETT before attempting to pass it through the endoscopy port of the anesthesia mask. This should decrease the possibility of introducing a diaphragm fragment into a patient’s airway.

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REFERENCES


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Fig. 1. Anesthesia mask with intact diaphragm (left). Anesthesia mask with damaged diaphragm following passage of #8 ETT (right).

Fig. 2. Diaphragm fragment.