The Anesthetic Management of the Patient with an Anterior Mediastinal Mass

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Severe respiratory and cardiovascular complications have been described in patients with an anterior mediastinal mass. Obstruction of major airways,1,2 superior vena caval obstruction,3 and cardiac compression4 are potential problems to be anticipated during general anesthesia. Three such cases are presented and the anesthetic approach to these patients is discussed.

REPORTS OF THREE CASES

Case 1. A 13-year-old 50-kg boy was scheduled to undergo cervical node biopsy under general anesthesia. He had a 4-week history of a dry cough. One week prior to admission he had mild facial swelling, one pillow orthopnea, and shortness of breath while playing football. On physical examination he had mild facial edema, bilateral paracardiac and left supraclavicular adenopathy, tubular but equal breath sounds bilaterally. Chest roentgenogram demonstrated a large anterior mediastinal mass with no tracheal deviation noted. Anesthesia was induced with 200 mg of thiamylal iv. Ventilation was controlled easily, and 40 mg of succinylcholine was administered iv followed by endotracheal intubation with a 7-mm cuffed tube. Following intubation, ventilation was impossible. The endotracheal tube was removed immediately, but ventilation via a mask was also unsuccessful. The trachea was reinserted rapidly and ventilation controlled for about 4 min, at which time adequate ventilation again became difficult to achieve. Within 2 min, a tracheostomy was performed but the airway remained completely obstructed. Two minutes later, a cardiac arrest occurred and pulmonary resuscitation was instituted. A ventilating bronchoscope was inserted. Total occlusion of the trachea starting 2–3 cm above the carina and extending to both main stem bronchi was observed. The bronchoscope was passed through the obstruction, and ventilation resumed about 4 min following the arrest. Resuscitation was unsuccessful. Autopsy demonstrated a lymphomass that infiltrated the carina, lungs, pericardium, and myocardium, and was adherent to the chest wall.

Case 2. A 16-year-old 68-kg boy who had been radiated for mediastinal Hodgkin’s disease was scheduled for a staging laparotomy. Six weeks previously, he had severe chest pain, cough, night sweats, loss of appetite, and a palpable 2-cm chest wall nodule over the right fourth anterior rib. Following the biopsy he underwent 13 radiation treatments with a subsequent decrease in the severity and incidence of cough, dyspnea, sweats, chest pain, and an improvement in appetite. On physical examination the nodule was noted, and breath sounds were clear and equal bilaterally. Chest roentgenogram revealed no evidence of tracheal deviation or constriction but marked hilar adenopathy. Anesthesia was induced with 200 mg of thiamylal iv, isoflurane, and nitrous oxide. Spontaneous ventilation was maintained following endotracheal intubation. Metocurine (12 mg) subsequently was administered iv, and ventilation was controlled easily. Following an uneventful staging laparotomy and splenectomy, paralysis was reversed with neostigmine 2.5 mg and atropine 1.0 mg iv. The patient was transferred to the recovery unit breathing spontaneously with the trachea intubated. After 15 min the patient became tachypneic and demonstrated chest wall retraction. Breathing sounds were absent on the left. With a PaO2 of 0.8, PaCO2 44 mmHg, PaO2 142 mmHg, Chest roentgenogram showed the endotracheal tube to be in proper position. Fiberoptic bronchoscopy through the tube revealed extrinsic compression of the left main stem bronchus on inspiration. The trachea was extubated successfully following 30 min of positive pressure ventilation and after complete emergence from the anesthetic. The remainder of his hospital course was uneventful.

Case 3. A 13-year-old 55-kg boy with an anterior mediastinal mass was scheduled for biopsy. He had been in good health until 3 days prior to admission, when mild chest pain developed that increased on inspiration. His appetite had decreased during this period and he had a low-grade fever. Physical examination was normal except for mildly decreased breath sounds bilaterally. Chest roentgenogram revealed a 7-cm right anterior mediastinal mass. Computerized axial tomography showed the mass at the level of the carina but not compressing the airway. Standard pulmonary function tests including a flow volume loop were performed in the upright and supine positions. Peak flow rate was reduced mildly in the upright position with the remainder of the variables within normal limits. In the supine position there were marked reductions in FEV1 and peak flow rates. The flow volume loop (fig. 1) demonstrated a plateau on the expiratory limb of the loop with the patient in the supine position. It was elected to perform the biopsy under local anesthesia. The local anesthetic was supplemented with diazepam 15 mg and fentanyl citrate 0.1 mg iv. The biopsy revealed Hodgkin’s disease. The patient was discharged and underwent mantle radiation to the mediastinum for 2 weeks at which
time he returned for staging laparotomy. The mass had decreased in size on chest roentgenogram. Pulmonary function tests including a flow volume loop (fig. 2) revealed essentially normal airway mechanics in the upright and supine positions demonstrating a marked improvement when compared with the preradiation studies. He underwent the procedure under general endotracheal anesthesia without difficulty and was discharged subsequently.

**DISCUSSION**

The preoperative diagnosis of an anterior mediastinal mass should alert the anesthesiologist to a potentially life-threatening situation. Numerous reports in the literature describe major airway obstruction in these patients while under general anesthesia.\(^1\)\(^-\)\(^3\) Keon\(^4\) described a patient with an anterior mediastinal mass who arrested during induction of anesthesia and was unable to be resuscitated. At autopsy the tumor was found enveloping the heart and infiltrating the pericardium. Case 1 illustrates the futility of trying to control ventilation of a patient with distal tracheobronchial obstruction through the proximal airway. Similarly, our patient had extensive mediastinal involvement including pericardial and myocardial infiltration by the tumor. Preoperative cardiac assessment should include electrocardiography and echocardiography in patients who are symptomatic. Piro et al.\(^5\) showed nearly a 10% incidence of acute life-threatening airway complications in a large group of patients with mediastinal Hodgkin's disease undergoing staging laparotomy. A number of these patients were asymptomatic and showed no airway compression on chest roentgenogram. Piro et al.\(^5\) recommend that radiation therapy be undertaken prior to general anesthesia whenever possible.

The response of lymphomatous tumors to radiation or chemotherapy is normally dramatic. Chest roentgenograms reveal a marked decrease in tumor size, and symptoms are usually improved, yet Case 2 illustrates a patient who responded to radiation therapy with a diminution in tumor size and improvement in symptoms but who developed airway obstruction during emergence from general anesthesia. Following radiation or chemotherapy, the radiologic appearance of the tumor must be reviewed, however, a dynamic evaluation of pulmonary function such as an upright and supine flow volume loop may be helpful.

Although most anterior mediastinal masses are lymphomatous in origin, a number of benign conditions such as cystic hygroma, teratoma, and thymoma can present in a similar fashion. A tissue diagnosis, therefore, is mandatory before radiation or chemotherapy can be undertaken. The patient presented in Case 3 required biopsy of the tumor mass for diagnosis. Preoperative computerized axial tomography (CAT scan) revealed no airway obstruction. The pulmonary flow volume loop, however, revealed a significant decrease in peak flow rate with the patient in the supine position. This pattern is consistent with intrathoracic airway obstruction, and the procedure was performed under local anesthesia as described. The flow volume loop graphically relates the instantaneous air flow rate (ordinate) to the lung volume (abscissa).\(^6\) The dynamic nature of this technique makes it an extremely sensitive tool for evaluating obstructive lesions of the major airways.\(^6\) The inspiratory limb of the flow volume loop is useful in diagnosing extrathoracic airway obstruction, and the expiratory limb is sensitive to intrathoracic airway obstruction. During inspiration, the pleural pressure is markedly negative compared with the intratracheal pressure. This tends to increase airway diameter and minimize the effects of intrathoracic airway obstruction.\(^7\) The upright and supine flow volume loops from Case 3 are illustrated in figure 1 and show the
compression was observed during inspiration upon emergence from the anesthetic. Obstruction during inspiration is more typical of an extrathoracic mass. However, during emergence a diaphragmatic mode of respiration with minimal chest wall motion can cause an intrathoracic mass to obstruct the airway during inspiration in the supine position. As the intercostal component becomes more prominent, the obstruction is minimized. This is likely to occur when the mass is fixed to the chest wall as in this case. Positive pressure ventilation was successful in treating this obstructive pattern until the patient has resumed a normal pattern of ventilation.

Figure 5 illustrates the approach to the patient with an anterior mediastinal mass. If signs or symptoms of airway compression, cardiac compression, or superior vena caval obstruction exist, general anesthesia should be avoided. In the asymptomatic patient, the series of noninvasive studies listed should be performed to rule out occult airway and/or cardiac involvement. An upright and supine flow volume loop, we feel, is the most sensitive noninvasive study for the diagnosis of airway obstruction. General anesthesia should be avoided if any of the tests are positive. Biopsies should be performed under local anesthesia and chemotherapy or radiation therapy should be instituted before the patient is reevaluated as a candidate for general anesthesia. For the patient who cannot be treated prior to a general anesthetic, such as, for the resection of a biopsy proven benign, radioinsensitive, or chemoinsensitive tumor, a number of precautions must be taken. Awake fiberoptic bronchoscopy to assess the degree of obstruction and the airway distal to the obstruction should be performed in older children and adults. Femoral vein to femoral artery cardiopulmonary bypass should be available at the time of induction. The remainder of the precautions listed in figure 3 should be followed for all patients with anterior mediastinal masses who require general anesthesia.

In summary, the patient with an anterior mediastinal mass is at great risk for general anesthesia and should be evaluated in an organized way that emphasizes the dynamic nature of the disease process.

REFERENCES
Unilateral Cervical Epidural

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Unilateral and partial epidural block is reported occasionally,1,2 but relatively rarely considering the frequency of lumbar epidural analgesia. A much less frequently performed block is that of the cervical region, which finds its main application in treatment of chronic pain such as tension-induced neck pain and headache. We also have observed in this region unilateral or partial block and in the following, we report one such case and its investigation.

REPORT OF A CASE

A 48-year-old man complained of dorsal and lumbar pain that had developed while he was working on an assembly line. Occasionally he was treated by his family physician and an orthopedic surgeon with physiotherapy without improvement. He started to complain of occasional numbness in the right hand. The remainder of his medical history was unremarkable, apart from minor changes seen on cervical roentgenograms. Two years ago he quit work because of the pain and continued to seek medical treatment, without relief. On examination, nothing remarkable was found apart from some suboccipital and cervical tenderness. There was no sensory deficit. He was diagnosed as having anxiety/depressive neurosis, tension headaches and possibly, subclinical osteoarthritis. A treatment program of cervical epidural block with local anesthetic, truncutaneous nerve stimulation, antidepressant medication, and psychotherapy was instituted.

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