Enlarged parathyroid gland – airway problem

To the Editor:

Anaesthetic problems associated with hyperparathyroidism are usually related to hypercalcaemic, renal or gastrointestinal symptoms.^{1,2} Patients for emergency parathyroidectomy may be comatose, dehydrated and require postoperative ventilation.^{3–5} We report an additional problem: a large parathyroid adenoma with tracheal deviation leading to difficult tracheal intubation.

A 50-yr-old man was admitted with hyperparathyroidism confirmed by hypercalcaemia, increased alkaline phosphatase, phosphorins, and urinary calcium excretion. Bilateral nephrocalcinosis and typical skeletal changes were seen in the hands and skull. Superior mediastinal CT scan showed a left paratracheal mass causing deviation of the trachea extending into the superior mediastinum (Figure). After premedication with 30 mg pentazocine and 25 mg promethazine *im*, anaesthesia was induced with 5 mg·kg⁻¹ thiopentone before giving 100 mg succinylcholine *iv*. Laryngoscopy was normal but an 8.5 mm endotracheal could not be passed beyond the vocal cords. Eventually the trachea was intubated with a 7.0 mm tube. The remainder of the anaesthesia was uneventful.

gland (P) causing deviation of the trachea (T) to the right.

Although the principal concern in anaesthetizing patients with hyperparathyroidism is their systemic manifestations, in this patient tracheal deviation by a parathyroid adenoma posed a serious intubation problem. As with thyroid goitres, the possibility of com-

promised airway with parathyroid adenomas should be kept in mind.

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Abbreviated laparotomy and planned re-operation

To the Editor:

Occasionally, trauma patients are so haemodynamically and metabolically compromised that prolonged surgery may threaten their survival. In these cases the surgeon may elect to shorten the surgery (abbreviated laparotomy, AL) and return to the operating room (planned re-operation, PR) when the patient has stabilized. Factors such as profound hypothermia (< 33°C), coagulopathy (PT > 15 sec), acidosis (pH < 7.18) and massive transfusion can lead to this decision.¹

We encountered three severely traumatized patients where the surgeon opted to conduct an AL. In two, the patients survived to return for PR. The third died of multiple organ failure and disseminated intravascular coagulopathy (DIC) after receiving 50 packs of blood products.

Abbreviated laparotomy is a revival of the abdominal packing employed 50 yr ago. Recently, the surgical criteria and strategies for performing AL and PR have been clearly outlined.² AL and PR consist of a short intervention aimed at controlling rapid haemorrhage, followed by a period of intense resuscitation in the ICU or PACU during which the patient can be

prepared for definitive surgery, while procedures such as bowel anastomosis, urethral reconstruction, etc., are undertaken only up to 36 hr after the initial injury when the patient has been adequately stabilized.²

Anaesthetists have an important role to play in the decision making on when and where to abbreviate the operation, when to return to the OR and in patient's resuscitation. It is thus surprising that this subject has not been discussed in the anaesthetic literature.

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