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is more profound in the elderly group compared with the non-elderly and super-elderly groups. The direct implications of this are still to be investigated. A possible explanation for our findings could be that while we rely on natural stamina of the non-elderly and meticulously care for the super-elderly, our care of the elderly group can still improve.

5692

## The hemodynamic effects of low-dose dexmedetomidine on anti-hypertensive medication at endotracheal intubation in elderly patients

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**Background and Goal of Study:** Dexmedetomidine is highly selective alpha 2 adrenergic agonist and preoperative administration of dexmedetomidine reduce sympathetic tone and maintain hemodynamic stability. Especially hemodynamic instability is more risky in elderly patients and then in elderly, preanesthetic 0.5 µg/kg single dose of dexmedetomidine effectively suppressed hemodynamic responses to endotracheal intubation. This study was investigated for the effect of a single low-dose preoperative dexmedetomidine (0.5 µg/kg) on antihypertensive drug (β-blocker, Ca-channel blocker) at endotracheal intubation (retrospective data collection).

**Materials and Methods:** Total 42 patients aged from 65 to 85, American Society of Anesthesiologists physical status II, either sex, undergoing elective noncardiac surgery were enrolled in the study. H-group had been treated with anti-hypertensive medications and N-group was normotensive patient with no medication. Patients who attempted endotracheal intubation more than 2 times were excluded. Morbidly obese patients who had BMI over 35 kg/m<sup>2</sup> also excluded. All patients were not premedicated. Anti-hypertensive medications were maintained until the day of surgery. After arrival of the patients at the operating room, patients were attached to a ECG, pulse oxymeter, and NIBP monitor. All patients were received 0.5 µg/kg of dexmedetomidine (Precedex; 200 µg/2ml; Hospira Inc., Lake Forest, IL, USA) for 10 min. After completion of precedex injection, propofol 1.5 mg/kg, rocuronium 0.6 mg/kg was administered. After two minutes endotracheal intubation was performed with a laryngoscope, and all intubation was performed within 30 seconds by one anesthesiologist. Anesthesia was maintained with sevoflurane in nitrous oxide/oxygen 50:50 mixture. vital signs (MBP, Pulse) were recorded at ward (baseline value), immediately after drug administration (after drug), 1, 3 and 5 minutes after endotracheal intubation.

**Results and Discussion:** The demographic data of the two groups showed in Fig. 1. There were no significant differences in demographic characteristics between groups. The MBP and Pulse changes of 2 groups were recorded in Fig. 2. There were no significant differences in cardiovascular changes between two groups.

**Conclusion:** The low-dose Dexmedetomidine was not showed the synergistic effects on cardiovascular depressive changes of anti-hypertensive drug at intubation.

5366

## Airway Management in Geriatric Patient with Airway Obstruction

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**Background:** Tumors located in the facial region, especially around the mouth and nose, and previous radiotherapy and surgical procedures in this region make mask ventilation and airway management difficult. We report a case of tracheostomy in a geriatric patient who needed airway patency and proved difficult to be ventilated through mask due to lower alveolar arch cancer involving the mandible.

**Case Report:** An 85-year-old, 153 cm, 45 kg, ASA 4E geriatric female patient underwent surgery for tracheostomy under emergency conditions because of airway obstruction. She had chemotherapy 7 months ago and radiotherapy 1 year ago and underwent total hip replacement surgery with epidural anesthesia 20 days ago. Mallampati score being 4, pronounced macroglossia was present and there was no area to place the mask on the face due to spreading cancer. Difficulty with mask ventilation was foreseen in the preoperative examination where intubation would prove difficult. For this reason, C-MAC videolaryngoscope, tracheostomy set, intubation tubes and stylets of different sizes were prepared beforehand. After standard anesthesia monitoring (HR: 110 / min TA: 170 / 120 mmHg SpO<sub>2</sub>: 92), preoxygenization was performed. During induction, 1 mg.kg<sup>-1</sup> 2% lidocaine

hydrochloride, 2 mg.kg<sup>-1</sup> propofol and 1 mcg.kg<sup>-1</sup> remifentanyl were administered, and the patient was quickly and serially intubated with C-MAC videolaryngoscope with endotracheal tube no 5. Anesthesia was maintained with 6% MAC desflurane, 50% oxygen and 50% air mixture. The operation lasted for 30 minutes. 5 minutes after the surgery, the patient's spontaneous respiration returned and sufficient tidal volume was reached in 10 minutes.

**Discussion:** Neoplastic tumors are often fragile and tend to bleed. Mask ventilation and tracheal intubation may cause marked edema and hemorrhage, leading to increased airway obstruction. In this case report, we emphasize the importance of rapid serial intubation with videolaryngoscopy without the use of nondepolarizing muscle relaxant in the provision of airway patency in a geriatric patient whose mask ventilation is quite difficult.

**Learning points:** Geriatric patient, airway management, videolaryngoscopy

6086

## Anaesthesia for pilonidal sinus surgery in a patient with Dilated cardiomyopathy. A case report

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**Background:** Dilated cardiomyopathy (DCMP), is a myocardial disease of varied causes characterized by dilatation of one or both the ventricles, impaired myocardial contractility, decreased cardiac output and increased ventricular filling pressures [1]. These patients are often at a risk of dysrhythmias or sudden cardiac death.

**Case Report:** We report the anesthetic management of a 70 year-old patient with DCMP undergoing for pilonidal sinus surgery under spinal anesthesia. Previous medical records revealed that patient was a diagnosed case of DCM since 9 years and his symptoms were well controlled with Tbl Cardiopirin, spirinolactone 25 mg, Carvedilol, Tbl Lisinopril 2 mg, Lasix 40 mg. Preoperative 12 lead ECG revealed Left bundle branch block. Echocardiography showed global hypokinesia of left ventricle and ejection fraction of 40 %. Patient was monitored with ECG, intermittent blood pressure measurement and pulse oximetry. The heart rate was 80 min and regular. The blood pressures were 120-70 mmHg. Spinal anaesthesia was administered, the patient received 2.5 ml of Bupivacaine 0.5%. Dural puncture was done in an aseptic technique at the L3-L4 level. The 22G spinal needle was used. Intravenous ephedrine 3 mg was administered after five minutes of spinal anaesthesia to correct hypotension 90/58 mmHg. The patient was haemodynamically stable throughout the surgery. During the surgery the patient was turned and put in prone position. Patient received a total of 1500 ml of crystalloid and urine output was 100 ml intraoperatively.

**Discussion:** Anesthetic management of patients with cardiomyopathy can be challenging and may be associated with high morbidity and mortality. Both general and regional anaesthesia have been used. The goals of anaesthetic management are avoidance of myocardial depression, maintaining normovolemia, avoiding overdose of drugs during induction as the circulation time is slow and to avoid sudden hypotension when regional anaesthesia is the choice [2].

### References:

1. Stoelting RK, Dierdorf SF (1993) Cardiomyopathy. In: Stoelting RK, Anaesthesia and Coexisting Disease. (3rd edn) USA, pp. 97-102.
2. Stoelting RK, Dierdorf SF (1993) Cardiomyopathy. In: Stoelting RK (Ed.) Churchill, Livingstone, New York, USA, pp. 97-102.

**Learning points:** In summary, the factors which ultimately favored the good outcome of this high-risk patient, were a thorough preoperative assessment, optimized cardiac status, anesthetic plans, postoperative monitoring and management of the complications.