



CASE REPORT

# Minimally invasive drainage of a giant retropharyngeal abscess

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## KEYWORDS

Airway obstruction;  
Suppurative infection;  
Pediatric

**Summary** *Objective:* To report a case of a 17-month-old female presenting with a giant retropharyngeal abscess and to outline the minimally invasive technique that was used to drain it. *Design:* Case study. *Results:* A previously healthy 17-month-old female was found by contrast-enhanced computed tomography (CECT) to have a retropharyngeal abscess (RPA) which extended from the level of the nasopharynx to the level of the aortic arch. The RPA measured 4.5 cm transversely, 2.7 cm antero-posteriorly and 8.0 cm cephalocaudally. After orotracheal intubation, transoral incision and drainage of the abscess was performed. Based on the CECT findings, the baby Yankauer suction was advanced 6 cm beyond the oropharyngeal incision (within the retropharynx) to break the distal septae and completely drain the RPA with a minimally invasive technique. *Discussion:* Our case describes the management of the largest RPA in the medical literature. We present the first report of the use of a baby Yankauer suction advanced through the oropharyngeal incision to drain intrathoracic RPA loculations.

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## 1. Case history and management

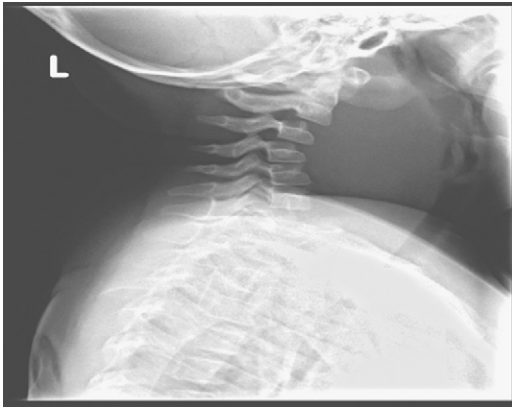
A previously healthy, 17-month-old female, presented to her community hospital with fever, nuchal rigidity and nausea. She was admitted to the local hospital and treated with intravenous penicillin for one day. Her symptoms improved and she was discharged home. However, over the next sixteen days, she developed progressive snoring, then low-pitched, biphasic stridor and drooling. A lateral X-ray suggested a massive RPA and considerable C-spine kyphosis (Fig. 1). P Contrast enhanced CT

(CECT) without sedation revealed that the RPA originated from a right node of Rouvier, crossed the midline at the level of the oropharynx and extended to the level of the aortic arch. The RPA measured 4.5 cm transversely, 2.7 cm antero-posteriorly and 8.0 cm cephalocaudally. It bulged anteriorly in the midline suggesting destruction of the midline raphe that usually bisects the retropharyngeal space. The RPA displaced the trachea and esophagus anteriorly and the great vessels laterally (Figs. 2–3).

The patient was intubated orotracheally at her community hospital. Intubation was reportedly moderately difficult secondary to anterior displacement of her larynx. Intubation was achieved with cricoid pressure and “hockey stick” technique. The

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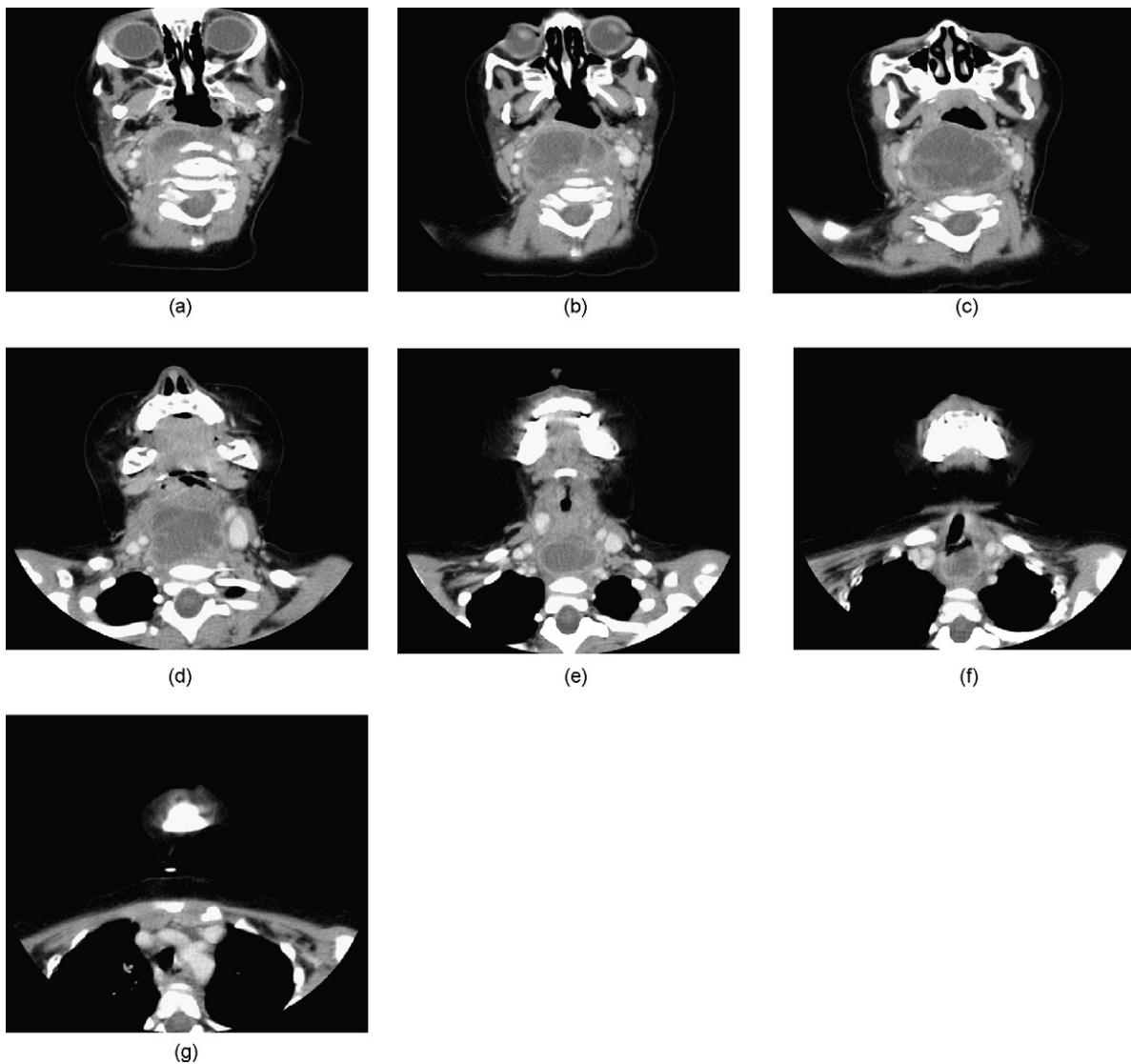


**Fig. 1** Lateral neck X-ray revealed a massive prevertebral swelling which caused cervical spine kyphosis.

patient was afebrile but her heart rate was 140/min and white blood cell count was 28 000/ml. Intravenous Clindamycin and Ceftriaxone were started and she was transported to BCCH by helicopter. She was brought to the OR for incision and drainage (I&D).

### 1.1. Details of operation

The patient was placed in the Trendelenberg position to help prevent potential aspiration of pus. There was no leak around the 4.5 cuffless standard endotracheal tube (ETT). A Jennings mouth gag was slid over the ETT tube, and slowly opened, then the tongue was carefully retracted. A large pale swelling of the right posterior oropharyngeal wall was noted. A 0.5 cm incision was made and copious pus



**Fig. 2** Axial CECT sections displaying the RPA originating from a right node of Rouvier (a) crossing the midline at the level of the oropharynx (b) and extending to the level of the aortic arch (c–g). These sections also show anterior displacement of the trachea and esophagus and lateral displacement of the great vessels.

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