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C-MAC D-Blade video laryngoscope for awake double lumen tube placement: A case report

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Key Words: Awake Intubation; Bronchopleural fistula; Video laryngoscope; C-MAC D-blade.

Abstract:

Awake intubation for double lumen tube placement is a challenging task even for experienced clinicians, for smooth intubation different techniques and equipment are always desired. We report the successful use of C-MAC videolayrngoscope as a tool for awake intubation and double lumen tube placement.

Introduction:

Awake intubation is mainly indicated in difficult airway, whereas awake placement of double lumen tube **(**DLT) have different sets of indications like proximal bronchopleural fistula (BPF), symptomatic mediastinal masses, complex hydatid cyst surgery, giant bullae etc.[1] Massive BPF posted for surgical intervention requires awake DLT placement to prevent volume loss, early desaturation and soiling of healthy lung.[1] Awake DLT placement is not as straight forward as awake intubation, but is more perplexing due to patient's non-cooperation, intact airway reflexes, preserved muscle tone, suboptimal glottic view, wider size of tube and more tube manipulation during intubation. We report successful intubation of two patients in first attempt by using C- MAC videolaryngoscope (C-MAC-VL) [C-MAC®D-blade, Karl Storz, Tuttlingen, Germany] for awake DLT placement.

Case Report:

Case 1: A 54-year-old man underwent a right sided bi-lobectomy of lung with mediastinal lymph node dissection. On postoperative day 5, patient developed low-grade fever, copious tracheal secretions, and persistent drainage of purulent pleural fluid from the chest tube. BPF was diagnosed with increasing air fluid level in the right pleural cavity on CT scan. Fiber-optic bronchoscopy (FOB) demonstrated purulent material trickling from a 5-mm-diameter BPF in the bronchial stump. The ongoing treatment included, intravenous antibiotics, chest