

Clinical image

Orotracheal Intubation in a Patient with Known Tracheal Diverticulum[☆]

Intubación orotraqueal en paciente con divertículo traqueal conocido

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Fig. 1. Reconstruction of the chest CT scan showing the diverticulum (indicated by the arrow).

We report the case of a female patient who underwent total knee arthroplasty. She had a history of scleroderma-related pulmonary fibrosis with a moderate restrictive pattern, schwannoma at L5, and syringomyelia at L4-L5. She had been operated previously for

a fracture of the tibia and fibula, with sequelae of paretic clubfoot. A chest computed tomography (CT) conducted in 2015 revealed a posterior tracheal diverticulum measuring 16 mm in the upper third of the trachea, with a 4 mm communicating orifice (Fig. 1).

The entrance of the tracheal diverticulum could be visualized by bronchoscopy with distal placement of the endotracheal tube cuff. This technique was selected to ensure that the distal tip of the endotracheal tube remained in this position, and to avoid the possible complication associated with mechanical ventilation of overstretching and rupturing the diverticulum.¹ No clinical changes or variations in ventilatory dynamics were observed during the intervention, and airway pressures remained normal. The patient was extubated without incidents after surgery.²

Bronchoscopy may be useful for the oro-tracheal intubation of patients with known tracheal diverticula, to ensure the correct positioning of the tube in order to avoid complications derived from mechanical ventilation.

References

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