**BLUNT LARYNGOTRACHEAL TRAUMA: AN ADRENALINE RUSH INDUCED AIRWAY MANAGEMENT**

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| Introduction  Blunt laryngotracheal trauma is rare but precarious, accounting for only 0.3% of trauma presentations, with mortality as high as 40%. It can result from various mechanisms such as traffic accidents (TA), falls and hanging attempts. A high index of suspicion is required as 33% can initially be asymptomatic posing a life-threatening treat in airway management.  Case description  A 55-year-old Indian gentleman was involved in TA and presenting to Emergency Department (ED) for hoarseness of voice and neck discomfort. Otherwise, he ambulates with few abrasion wounds on shoulder. Upon returning from radiograph, he deteriorates while having dyspnea and hemoptysis immediately rushed to resus zone for airway obstruction. Cervical xray reviewed showed extensive subcutaneous emphysema with hyoid bone fracture. Eventually, he was intubated for airway control with glidescope while ENT on standby. During intubation noted pooling of blood on vocal cord with anatomical distortion. First attempt Intubation success with bougie assistance and gentle suction. No episode of desaturation monitored as passive apnoeic oxygenation was applied with nasal prong 15litre/min, preoxygenation with HFM 15litre/min and titrated dosage of ketamine. Bilateral chest tube was inserted for extensive subcutaneous emphysema. He was haemodynamically stable throughout ED stay prior ICU admission.  Discussion  The hallmark of airway management is maintenance of spontaneous ventilation, intubation under direct vision to avoid false passage creation and avoidance of both intermittent positive pressure ventilation and cricoid pressure during rapid sequence intubation. For the uncooperative time-critical patient with inadequate pre-oxygenation, a delayed sequence induction is recommended with two-person technique, usage of small boluses of ketamine to achieve sedation, preserve airway reflexes, and maintain spontaneous breathing. Once sedation is achieved, is recommended to apply tight fitting high flow mask with oxygen flow rate to 15 L/min. To support apnoeic oxygenation, nasal specs at minimum rate of 10 L/min should also be applied prior to induction and throughout intubation.  Conclusion  Due to limited experience in the management of airway injury, advisable for clinicians to consolidate their knowledge through mechanisms such as high-fidelity simulation training and by attending workshops specifically for the management of airway trauma.  Keywords  Laryngeal trauma, airway management |