Dear editor,

Post laryngectomy patients with tracheal stoma undergoing any other surgery under general or regional anesthesia pose unique perioperative anesthetic challenges. There is meagre literature on anesthetic management of such patients.\(^1\)

A 47 years old male (58 kg), (consent for publication obtained from patient) who had undergone total laryngectomy with left hemithyroidectomy 10 yrs. back for transglottic carcinoma was now scheduled for Transurethral resection of bladder tumor confined posterior bladder wall. Patient was on tablet Thyroxine 75 mcg. There were unique challenges associated with managing this patient. Communication with these patients during pre-anesthetic check-up is provocative. Though, he was trained for esophageal speech, but attendant help was required for better history taking. These patients should cover stoma with a surgical mask in addition to face & mouth to prevent spread of covid-19 infection to others.\(^2\) Determination of tracheostomy tube size is a daunting task which was facilitated by otorhinolaryngologist consultation and roentograph of neck (AP & lateral view). Stoma was healthy and Tracheostomy tube size 8/7.5 mm was determined to be suitable in case of need. Such patients have possible difficult central venous catheter insertion due to distorted neck anatomy and difficult IV access post chemo & radiotherapy.

Following informed written consent and adequate preoperative counselling, patient was planned for surgery under Subarachnoid block with 2.2 ml of 0.5% bupivacaine heavy with 20 mcg fentanyl targeting block level up to T 10 for this case. Lithotomy position was given only after block level had fixed for prevention of ascent of the level. Assessment of height of spinal anesthesia block was next road blocker. With the help of sign language taught in the preoperative area, spinal block height was estimated. Obturator nerve block was not administered as tumor was not involving lateral wall of urinary bladder.

Oxygenation in these cases is not feasible through any of the oxygenation devices attached to the face. Oxygenation was done via stoma using auxiliary port tubing along with capnometer as depicted in Figure 1.\(^1\) Stoma was covered with a sterile gauze piece from above to prevent entry of any foreign body which can be detrimental to the patient. Intraoperative course was uneventful, and patient was shifted to post anesthesia care unit post-surgery.

---

**Anaesthetizing post laryngectomy patient: Unique challenges**

---

**Figure 1:** (a) Tracheal stoma with oximeter port (b) Capnometer attachment
Hence to conclude, intense vigilance, monitoring and close loop communication with the surgeons is of utmost importance in managing these cases.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

Nisha Jain, Manpreet Kaur, Gurudarshan S, Prayosikta Lenka
Department of Anaesthesiology, Pain Medicine and Critical Care, All India Institute of Medical Sciences, New Delhi, India

Address for correspondence:
Dr. Manpreet Kaur,
Department of Anaesthesiology, All India Institute of Medical Sciences, Room No. 5007, 5th Floor Teaching Block, New Delhi - 110029, India.
E-mail: manpreetkaurrajpal@yahoo.com

References
1. Bhargava S, Kasliwal A, Parashar S, Parashar VK, Goyal V, Bana A. Anaesthetic management of a post laryngectomy patient undergoing CABG. Ann Card Anaesth 2005;8:64–6.
2. Brook I. Prevention of COVID-19 infection in neck breathers, including laryngectomees. Int Arch Otorhinolaryngol 2020;24:e253–4.