Incidental Finding of Idiopathic Sub-glottic Stenosis in a Patient Managed for Drug Overdose

Sir,

The most frequent causes of sub-glottic stenosis are endotracheal intubation and tracheostomy. But, congenital factors and acquired causes i.e., benign and malignant tracheobronchial tumours, neck trauma, chronic inflammatory diseases, such as Wegener’s granulomatosis, sarcoidosis, and relapsing polychondritis, can also result in tracheobronchial stenosis.1 Anaesthesiologists may come across sub-glottic stenosis in emergent situations; and management of the airway in such conditions, depends on location and severity of tracheal stenosis. Thus, timely diagnosis and early involvement of the multidisciplinary team may lead to safe airway establishment and post-extubation management.

Immediate CT neck was performed that showed sub-glottic stenosis measuring 1.5 cm in length in the trachea with the narrowest opening of 5 mm (Figure 2 A and B). She was intubated again, on the bedside, with micro-laryngeal tube size of 6 mm I.D, in the presence of ENT team and all emergency drugs and equipment followed by the continuation of high dose steroids and sedation for 48 hours in ICU.

Tracheal stenosis can have varied presentation. Endoscopy, CT scan and spirometry can be performed as preferred investigations for diagnosis.2 We ruled out the congenital and acquired causes of tracheal stenosis before making our final diagnosis. Management of idiopathic tracheal stenosis can be challenging, and it includes mechanical dilation using rigid bronchoscopy or balloon dilation with flexible bronchoscopy, along with more extensive surgeries.3,4

A multidisciplinary team approach can be helpful in early diagnosis and timely management.

CONFLICT OF INTEREST:
The authors declared no conflict of interest.

AUTHORS’ CONTRIBUTION:
SI, SL, EK: Literature search, and initial write-up.
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