

A Case of a Pharyngeal Injury Caused by Laryngeal Tube Suction Insertion

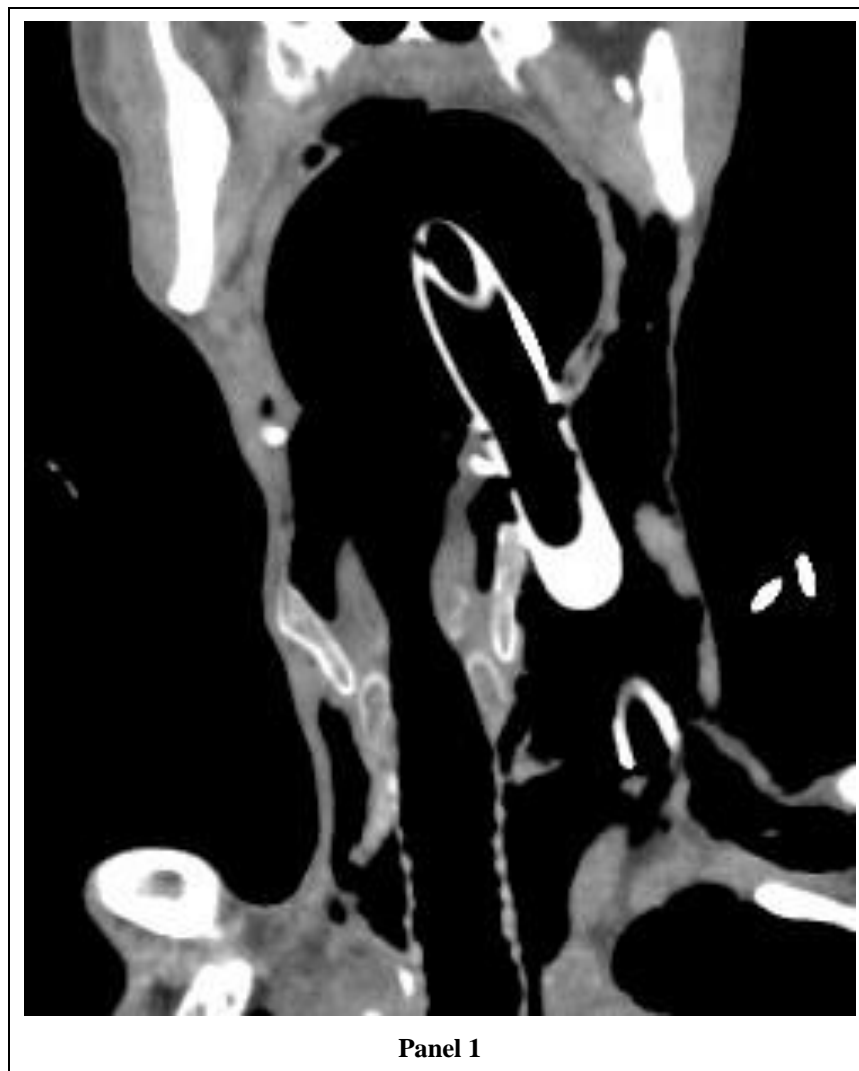
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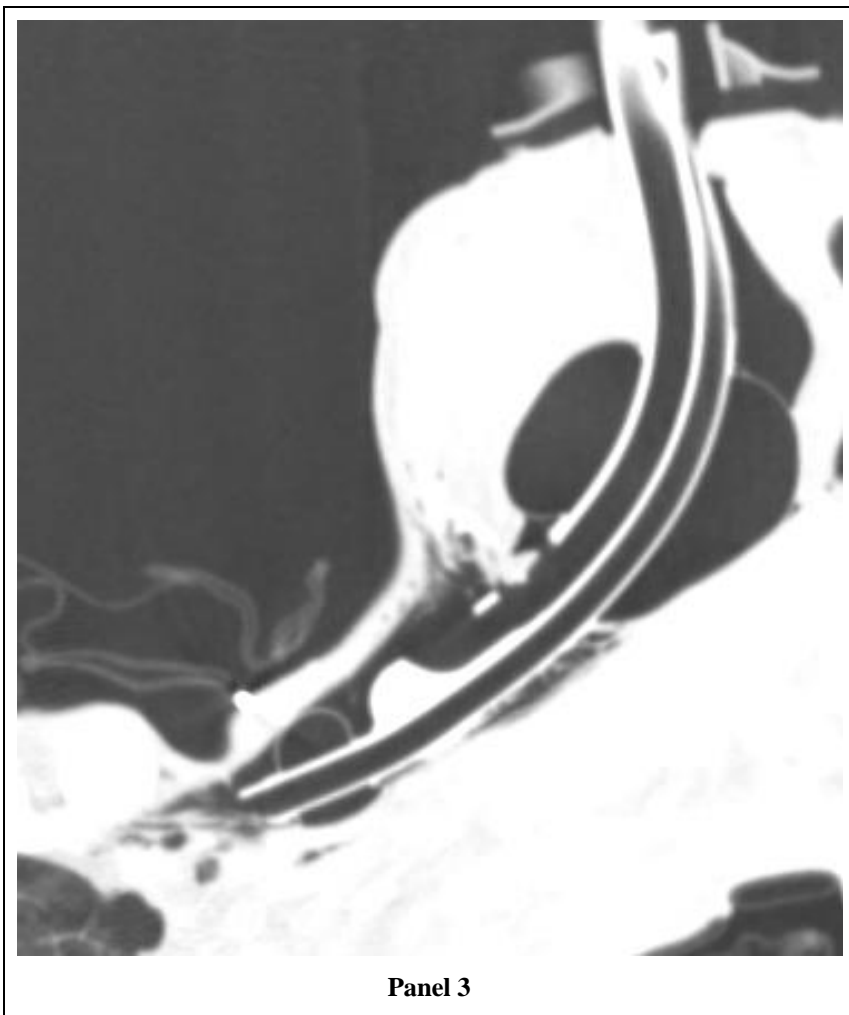
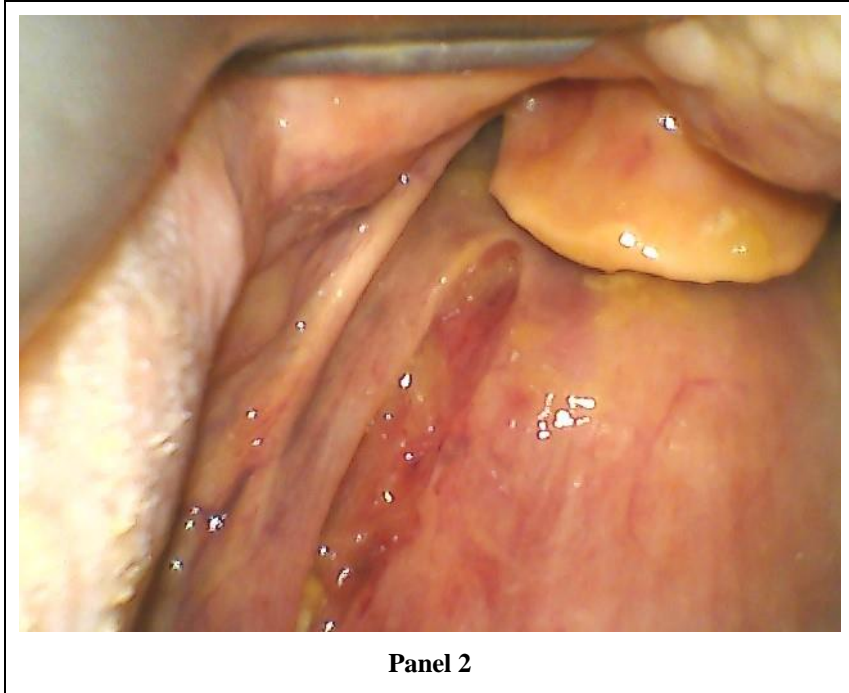
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Clinical Image

A 90-year-old man was found collapsed on a road by a passerby who called for emergency medical assistance. The time of the collapse happened was unknown, and his initial electrocardiogram waveform was asystole when the paramedics arrived. The paramedics inserted a Laryngeal Tube Suction (LTS) and the patient was taken to the hospital. After insertion, there were no abnormalities in chest rise, breath sounds, or capnograms. After arrival at the hospital, cardiopulmonary resuscitation was continued while observing the entire body. Subcutaneous emphysema was observed in the left neck. Subsequently, it was determined that saving his life was impossible, based on the initial waveform, age, and the time that had elapsed, and resuscitation was discontinued. Computed tomography (CT) was performed to identify the cause, which revealed that the LTS had moved into the left side of the neck (Panel 1).

In addition, a video laryngoscope (C-MAC®) was used to confirm the cause, and damage was found to the left posterior pharyngeal wall (Panel 2).

One possible cause of the LTS becoming dislodged was that lubricating jelly was not applied at the time of insertion, and it has been decided that lubricating jelly will be applied in all cases in the future. As for constant ventilation, it was considered that ventilation was possible because part of the LTS ventilation port did not stray into the posterior wall of the pharynx and was facing towards the trachea (Panel 3). Consequently, the cause of death in this case was extensive pneumonia, and injury to the posterior wall of the pharynx due to aberrant LTS could not have affected the prognosis; however, medical professionals involved in cardiopulmonary resuscitation should be aware that such complications can occur.