

# AIRWAY MANAGEMENT IN A SEVERE SCHIZOPHRENIC WITH AN ANTERIOR MEDIASTINAL MASS

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## Presentation:

- 54 y/o male presents with persistent anemia.
  - Other PMH:
    - HTN, GERD, sickle cell trait, polysubstance abuse
    - Severe schizophrenia
  - Inpatient at a local mental health institution
  - Could not cooperate or consent with any part of medical care
- Admission labs confirmed significant anemia (Hgb 5.2)  
Diagnosed with RUL lung mass, invading anterior mediastinum



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## Studies:



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### Clinical Course:



Initially planned for EBUS with bx for tissue diagnosis  
 Ethics consult due to patient's poor prognosis, inability to cooperate with sedation and being high risk for intubation.  
 Final, agreed upon plan was:

- Intubation by anesthesia
- 5 day course of palliative radiation
- Patient to remain intubated, sedated in ICU while undergoing treatment
- Extubate when able, transfer to appropriate palliative facility

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### Preoperative assessment:



Past medical assessment as noted on this admission  
 Patient unable to answer questions regarding PMH, PSH, past anesthetics, ROS  
 Physical exam:

- Cachectic male, appears older than actual age
- Laying approximately flat in bed, no respiratory distress
- No signs of SVC compression
- RRR, breath sounds diminished in right apex
- Unable to perform airway exam due to lack of patient cooperation

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### Anesthetic plan:



Pre-induction sedation with midazolam  
 Transport to OR, preoxygenate and establish LE IV access  
 Initiate dexmedetomidine infusion  
 Induce anesthesia with ketamine, inhaled sevoflurane  
 Airway topicalization  
 Indirect videolaryngoscopy for intubation with armored ETT  
 Confirm ETT placement with flexible bronchoscopy  
 Transport for XRT, return to ICU

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## Anterior mediastinal masses:



Broad differential diagnosis

Significant implications with inducing and maintaining anesthesia

- Airway compromise
- Potential loss of upper extremity IV access

Principles in management

- Pre-operative assessment
- Maintain spontaneous ventilation
- Establish lower extremity IV access prior to induction of anesthesia

**References:**

Stoelting, R. K., Hines, R. L., & Marschall, K. E. (2012). *Stoelting's anesthesia and co-existing disease*. Philadelphia PA: Elsevier Saunders.  
Miller, R. D. (2015). *Miller's anesthesia*. Philadelphia PA: Elsevier Saunders.

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