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

Studies:
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

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

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
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: