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An unusual presentation of undiagnosed Gastro Esophageal Reflux Disease (GERD) during general anesthesia for an elective surgery

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A 50 year old female, ASA 1 with normal airway examination underwent general anesthesia for total knee arthroplasty. After induction with propofol 150 mg and fentanyl 75 mcg, bag mask ventilation was attempted and found to be difficult. An Ambu® Auragain supra-glottic airway, size 3 was inserted without any difficulties. Airway pressure was noted to be persistently high despite further boluses of propofol and administration of atracurium. A ProSeal™ LMA of size 4 was changed; however, airway pressure remained high without any improvement in tidal volumes delivered. Bronchospasm was excluded with auscultation. Decision was made for endotracheal intubation and she was intubated with a Portex® ETT, size 7.5. Direct laryngoscopy revealed edematous large epiglottis without any evidence of trauma. Post intubation airway pressures were normal without any leak, suggesting that the ventilation problem was likely supraglottic. A video laryngoscopy was performed to further examine the laryngeal structures, revealed an edematous posterior arytenoid and large swollen epiglottis. (See image). An ENT surgeon was consulted prior to extubation and our patient was extubated, with the availability of necessary backup airway equipment for reintubation if required. A nasoendoscopy was performed, showing a small larynx, a patent airway with mild posterior arytenoid oedema with granulomatous appearance suggesting chronic inflammation. Vocal cord abduction and adduction were normal. A diagnosis of laryngo-oesophageal reflux was made and our patient was started on oral pantoprazole. Further interrogation revealed that the patient had features of gastro-oesophageal reflux disease (GERD) symptoms and hoarseness of voice over the last couple of months. GERD can lead to laryngo pharyngeal inflammatory changes. This rare case highlights how an undiagnosed GERD may impact on anesthesia management and educate the anesthetist to be more vigilant to routinely look for GERD symptoms and evidence of reflux laryngitis in patients with GERD.

Recent Publications

1. Silva C E D da, Niedermeier B T, Portinho F (2015) Reflux laryngitis: correlation between the symptoms findings and indirect laryngoscopy. International Archives of Otorhinolaryngology 19(3):234–237.
2. Gregory N Postma and Stacey L Halum (2006) Laryngeal and pharyngeal complications of gastroesophageal reflux disease. GI Motility Online doi:10.1038/gimo46.
3. Vaezi Michael F, et al. (2003) Laryngeal signs and symptoms and gastroesophageal reflux disease (GERD): a critical assessment of cause and effect association. Clinical Gastroenterology and Hepatology 1(5):333–344.
4. Koufman J A, Amin M R and Panetti M (2000) Prevalence of reflux in 113 consecutive patients with laryngeal and voice disorders. Otolaryngol Head Neck Surg. 123(4):385–388.
5. Ahuja V, Yencha M W and Lassen L F (1999) Head and neck manifestations of gastroesophageal reflux disease. Am Fam Physician 60(3):873–80.

Biography

Jinghui Chen is a Senior Resident in Anaesthesia in his penultimate year of training. His interests include intensive care medicine, and clinical ultrasound in critical care.

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