

Flow Charts Illustrating the Sudden Decline Due to Undetected Mediastinal Mass

Uma Hariharan*

Anesthesia and Intensive Care, Dr Ram Manohar Lohia Hospital, New Delhi, India

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Introduction

Mediastinal masses can manifest with diverse presentations or remain asymptomatic until advanced stages [1]. While there is existing literature on the anesthetic management of patients with mediastinal masses [2], information is scarce regarding the acute presentation and subsequent developments following airway interventions in individuals with undetected mediastinal masses, particularly in emergency or critical care scenarios. When these masses present as reactive airway disease or acute airway obstruction, the potential existence of a mediastinal mass should be considered, especially if conventional medical management proves ineffective or if definitive airway interventions exacerbate the condition. In cases where patients are hemodynamically stable, contrast-enhanced computed tomography [3] can be utilized for the diagnosis of mediastinal masses. Positive pressure ventilation [4] can be perilous due to increased intra-thoracic pressures. Early consultation with a cardiothoracic surgeon is advisable, and prophylactic cannulation of femoral vessels may be considered. Intensive care units managing patients with mediastinal masses must have facilities for initiating life support or ECMO [5] (extracorporeal membrane oxygenation).

Discussion

Mediastinal masses can pose a diagnostic challenge, often

Corresponding author:

Uma Hariharan, Anesthesia and Intensive Care, Dr Ram Manohar Lohia Hospital, New Delhi, India. E-mail: uma_hariharan@gmail.com

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masquerading as other respiratory conditions such as bronchial asthma, COPD exacerbation, or subglottic stenosis [6]. In emergencies, heightened awareness, continuous vigilance, and swift responses are crucial. This article presents a succinct, clear, and systematic four-step approach to comprehending

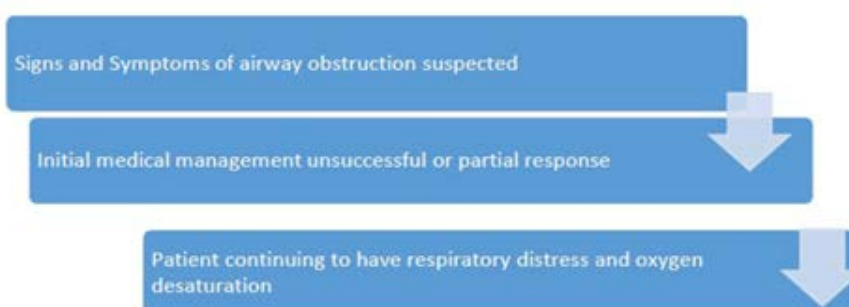
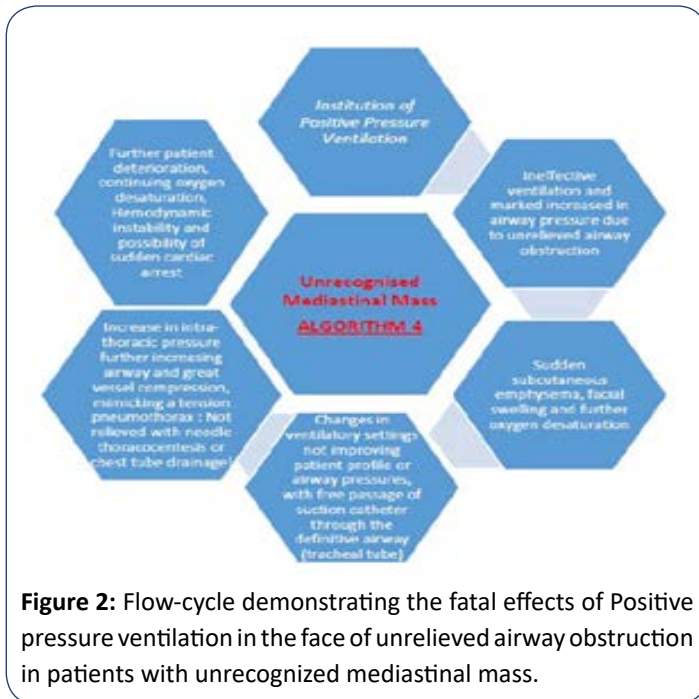


Figure 1: Flowchart depicting unrelieved airway symptoms in unrecognized mediastinal mass.



the progression of airway obstruction caused by mediastinal masses. The following series of four flow charts or algorithms (to be sequentially reviewed) outline the sequence of events that may unfold after the insertion of a definitive airway, suspecting airway obstruction in a patient with a pre-existing unknown or unrecognized mediastinal mass (Figures 1-2).

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