



Unusual Complication After TTE: a Simple Management

Deepthi Ahuja¹ · Kinshuki Jain¹ · Saurabh Vig¹ · Sachidanand Jee Bharati¹

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Sir,
Trans-thoracic esophagectomy (TTE) is an established surgical procedure for management of patients with esophageal cancer. The perioperative management of these patients is undoubtedly challenging due to the disease itself, preoperative chemoradiation therapy received, presence of comorbidities, and intraoperative requirement of lateral decubitus position, open pneumothorax, and one lung ventilation and management of various postoperative complications. Postoperative pulmonary complications including pleural effusions, atelectasis, chylothorax, pneumonia, pulmonary embolism, and respiratory failure are common causes of morbidity after esophagectomy [1]. We report an under-documented cause of air leak and its management that may occur postoperatively in these patients. A 70-year-old male, known case of carcinoma esophagus, who underwent TTE with extended two-field lymphadenectomy with gastric pull-up with cervical neck esophagogastric anastomosis under epidural and general anesthesia, was admitted to our intensive care unit (ICU) for observation and pain management. The patient had preoperatively received 5 cycles of carboplatin and paclitaxel-based chemotherapy and 25# of radiotherapy. The medical history was unremarkable except for the presence of features suggestive of obstructive sleep apnea (OSA). The anesthetic management and monitoring were done as per institutional protocol. As a part of operative procedure, right intercostal drain (ICD) and

corrugated neck drain were also placed. The intraoperative period was uneventful. Two hours after ICU admission, we observed air leak in right ICD. Chest X-ray was done immediately to confirm the position of ICD (Fig. 1). As the chest X-ray confirmed that ICD was in the correct place in the pleural cavity. In spite of the presence of air leak, the vital parameters including SpO₂, heart rate, and blood pressure were within normal limits. Hence, instead of directly going for any intervention, we decided to further explore the cause of air leak. We examined the dressing in the neck region covering the corrugated drain (Fig. 2). We found that the dressing had gotten loose and air was getting sucked in from the wound. Thus, we decided to cover the neck incision with an airtight dressing. Immediately after changing the dressing, we found that the air leak had disappeared. In a case report by Kumar et al., authors have reported that the corrugated neck drains placed during TTE is a cause of iatrogenic pneumothorax. But, for the management, patients were managed with high flow oxygen therapy followed by endotracheal intubation and mechanical ventilation, and fiberoptic bronchoscopy insertion of

✉ Sachidanand Jee Bharati
sachidadr@yahoo.co.in

Deepthi Ahuja
deeptiahuja2252@gmail.com

Kinshuki Jain
dockinshukijain@gmail.com

Saurabh Vig
saurabh377@yahoo.com

¹ Department of Onco-Anaesthesia and Palliative medicine, Dr B.R.A.I.R.C.H, All India Institute of Medical Sciences, Room no 139, First floor, New Delhi, India



Fig. 1 Chest X-ray showing Right ICD in situ



Fig. 2 Corrugated neck drain after removal of dressing

another ICD and subsequently by removal of cervical drain and suture of defect [2].

We found that simple measure like covering the surgical incision with airtight dressing can stop further air leak. Thus,

we would like to emphasize that postoperative clinical findings may mislead clinicians to suspect grave complications, which may not be true. At the same time, addressing the exact cause prevents all unnecessary interventions that may further complicate the clinical course increasing both morbidity and mortality. Finally, we suggest that keeping a high degree of suspicion of air trapping through corrugated neck drain and covering the neck incision with airtight dressing can prevent a catastrophic complication.

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