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BROKEN TRACHEOSTOMY TUBE PRESENTING AS TRACHEOBRONCHIAL FOREIGN BODY: A RARE CASE REPORT

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ABSTRACT

Fracture of tracheostomy tube is a rare entity. It can present as tracheobronchial foreign body and can lead to fatal airway obstruction, if not intervened timely.[1] Only few case reports of fractured tracheostomy tube have been reported so for in the literature. We are presenting a case report of fractured tracheostomy tube wich was stuck at carina and into left main bronchus.

INTRODUCTION

Different types of foreign bodies have been reported in literature, however, fractured tracheostomy tube is a rare one. Tracheostomy is a common and prolonged method of securing airway. Tracheocutaneous fistula and tracheal stenosis are known complications. Prompt diagnosis and interventions are a must in such situations. We are reporting an operated TOF with tracheostomy tube for 82days presenting as foreign body at carina and left main bronchus.

CASE REPORT

A 3 years old female presented in CVTS department as a case of TOF on 1/7/2016and was operated on 3/7/ 2016. She was shifted to cardiac ICU for postoperative monitoring and ventilation. Patient was extubated on first post-operative day, but was reintubated after 30 minutes due to carbon dioxide retention. She was having contineous bilateral intercostal tube drainage. She was tracheostomised on 7th POD with pvc size 4.5 and was gradually weaned off from ventilator to trachcollar on oxygen. Tracheostomy tube was taken out but Patient got tachypnic and tube was reinserted again. Tracheostomy care and tube was changed regulary. On 89 POD ventilator suddenly displayed that patients is not getting ventilated. Suction catheter was inserted to check for tubal patency, but there was no feel of intact tube.

However, it was noticed that tracheostomy tube has broken from neck plate, gone to the trachea and was invisible. Patient developed signs of respiratory obstruction (patient got cyanosed saturation dropped to zero but there was no bradycardia). She was taken on face mask with ambu ventilation continuously. Tracheostomy hole was covered with gauze and saturation was raised to 72%-74% maximum. Intervention for broken tube removal was done at 72% saturation and stopped at 45% till saturation was raised to 72%. Airway was secured with face mask for 30 minutes. LMA was introduced while giving midazolam 1mg and fentanyl 20microgram and put on ambu ventilation with intermittent gauze application. There was decreased chest rise on left side. Incision was extended on trachea and tracheostomy tube was still invisible. Meanwhile rigid bronchoscope was arranged and foreign body was identified at carina and removed. New tracheostomy tube was placed and patient was put on ventilator for some time. patient was completely awake after 30 minutes with GCs of 15/15.

DISCUSSION

A number of complications of tracheostomy tube have been reported in literature oftenly, but fracture rarely. Bosoe and Boe (1960) reported first fracture of TT.[2] In India Maru Y. K. et al (1978) reported first case.[3] Alvi anf Zahtz found 11 cases of non synthetic and 12 cases of synthetic tube fracture.[4] Gupta reported 9 cases in 1987 in 8 years.[5] Aspiration into right main bronchus is common[6] but ours was at carina and into left main bronchus.

Tracheostomy tube can be metallic, PVC and silicon. Fracture of metallic TT is commonly

due to corrosive action of alkaline tracheal secretions. PVC tube less likely gets fractured, but gets dislodged from neck plate. Predisposing features for fracture are, weak junctions, manufacturer error and prolonged usage. Rigid bronchoscope is main method of removal.

CONCLUSION

Best way to minimise this complication is ensure quality of material, tracheostomy care, regular follow up, repeated change of tracheostomy tube and discourgement of prolonged tracheostomy tube usage beyond its recomended time.

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