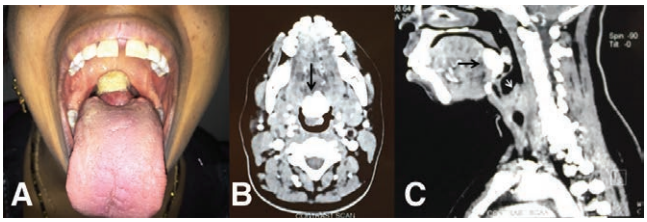
Charles D. Collard, M.D., Editor

Lingual Thyroid

Bikram Kishore Behera, M.D., Satyajeet Misra, M.D., D.N.B., P.D.C.C., T.E.E. Certified (E.A.C.V.I.), F.T.E.E., Pradipta Kumar Parida, M.S., D.N.B.



A 32-yr-old woman presented to the anesthetic clinic for preoperative evaluation for excision of a lingual thyroid. The pink mass was seen in the midline at the base of tongue and partly covered with yellow slough (Panel A). Contrast computed tomography showed the well-defined homogenously enhancing mass (black arrow) at the base of tongue (Panels B and C). The mass was not encroaching on the epiglottis (white arrow), and there was no evidence of airway obstruction.

Lingual thyroid is a rare developmental anomaly and results from failure in descent of the thyroid gland from the foramen cecum to its normal prelaryngeal site.[1] The prevalence is 1:100,000 to 1:300,000 with a female:male ratio of 4:1.[1]

There are no predictors of a difficult airway in patients with midline lingual masses, and oral examination may not reveal any abnormality, especially with more posteriorly located masses.[2] Asymptomatic patients may present with difficulty in mask ventilation and/or intubation due to pressure effects of the mass on the epiglottis.[2] Oral airway insertion to prevent tongue collapse after anesthesia induction or direct laryngoscopy and oral intubation may result in significant bleeding due to trauma to the glandular tissue.[1]

In this case, we have planned to secure the airway with awake flexible bronchoscopy.[3] In patients presenting with difficult airway due to undiagnosed lingual masses, video-assisted, laryngoscopy-guided intubation is an option and may be better than a laryngeal mask airway or flexible bronchoscopy because it is a visually guided procedure and the vallecula can be mechanically lifted to visualize the glottis.

Competing Interests

The authors declare no competing interests.

Correspondence

Address correspondence to Dr. Misra: misrasatyajeet@gmail.com

References

1. Buckland RW, Pedley J: Lingual thyroid: A threat to the airway. Anaesthesia 2000; 55:1103–5
2. Ovassapian A, Glassenberg R, Randel GI, Klock A, Mesnick PS, Klafta JM: The unexpected difficult airway and lingual tonsil hyperplasia: A case series and a review of the literature. ANESTHESIOLOGY 2002; 97:124–32
3. Apfelbaum JL, Hagberg CA, Caplan RA, Blitt CD, Connis RT, Nickinovich DG, Hagberg CA, Caplan RA, Benumof JL, Berry FA, Blitt CD, Bode RH, Cheney FW, Connis RT, Guidry OF, Nickinovich DG, Ovassapian A; American Society of Anesthesiologists Task Force on Management of the Difficult Airway: Practice guidelines for management of the difficult airway: An updated report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway. ANESTHESIOLOGY 2013; 118:251–70

From the Departments of Anesthesiology (B.K.B., S.M.) and Ear, Nose, and Throat (P.K.P.), All India Institute of Medical Sciences, Bhubaneswar, Odisha, India.

Copyright © 2017, the American Society of Anesthesiologists, Inc. Wolters Kluwer Health, Inc. All Rights Reserved. Anesthesiology 2017; 127:891

Copyright © 2017, the American Society of Anesthesiologists, Inc. Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

<zdoi;10.1097/ALN.0000000000001743>

Downloaded from http://asa2.silverchair.com/anesthesiology/article-pdf/127/5/891/379008/20171100_0-00030.pdf by guest on 20 March 2024