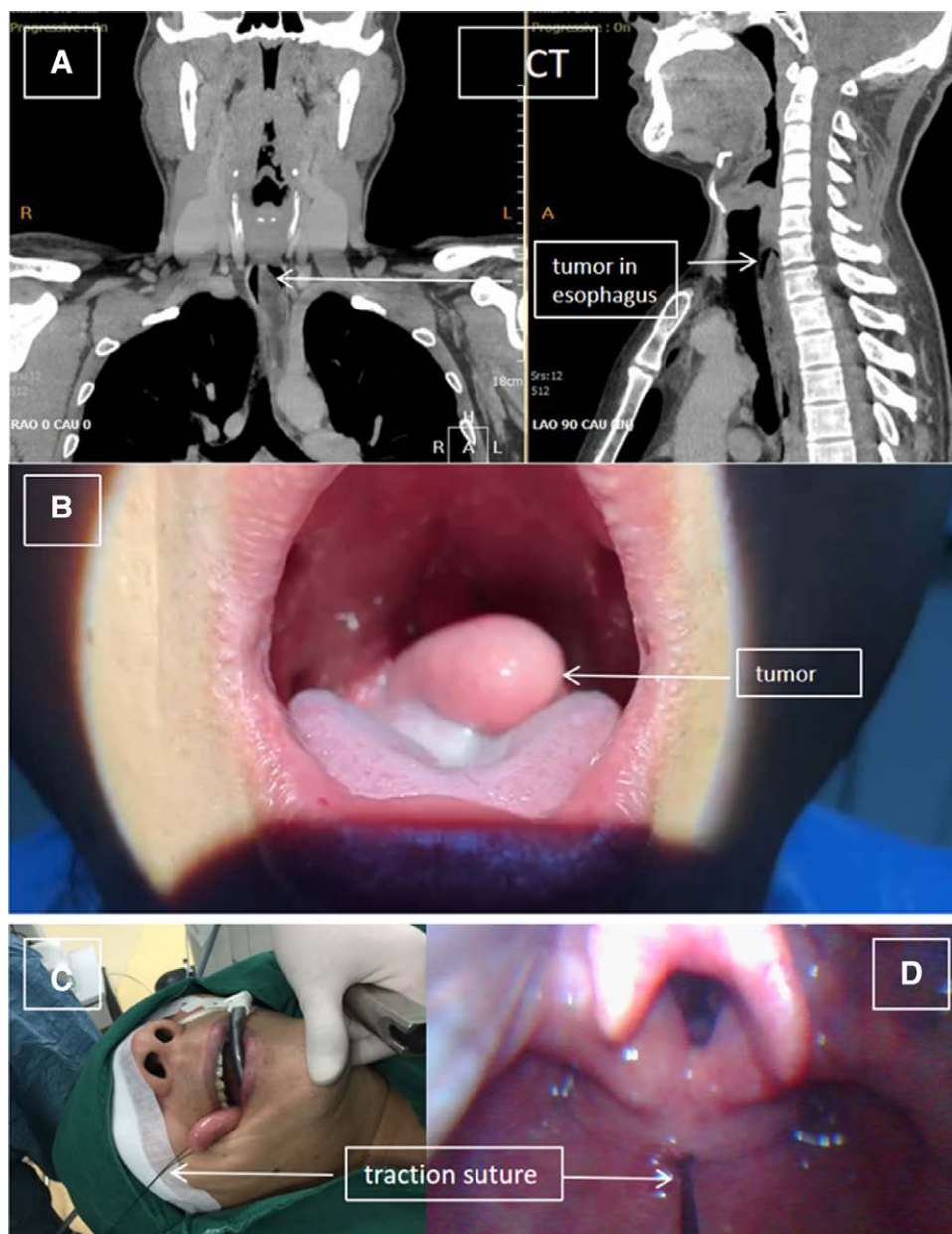


# Securing and Mobilizing an Esophageal Mass before and after Endotracheal Intubation

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A patient was scheduled for upper esophagus tumor resection under general anesthesia. A large mass ( $14 \times 2 \times 2$  cm) was found in the esophagus (panel A). The

mass could be regurgitated freely to the mouth (panel B) and swallowed back into the esophagus. The patient denied significant difficulty breathing or swallowing. To

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achieve the surgical view with suspension laryngoscopy, the surgeon requested that the mass be kept in the mouth intraoperatively. Awake intubation was discussed because of a concern for airway compromise after induction but not performed due to patient refusal. Instead, tracheal intubation was performed after induction. To ensure the mass was swallowed into the esophagus during induction/intubation and pulled back into the mouth for surgery after intubation, the tip of the tumor was anchored with a suture after topicalization and before induction (panel C). Then the patient was asked to swallow the tumor with adequate slack of the retraction suture. After induction, mask ventilation was effective and direct laryngoscope revealed a grade I view of the glottis. The retraction suture, but not the tumor, was visible during laryngoscopy (panel D). Tracheal intubation was performed with videolaryngoscopy. On confirmation of the correct endotracheal tube placement, the mass was successfully resected.

A mobile mass or tumor originating from the pharyngeal cavity or upper segment of the esophagus imposes the risk of a difficult airway. If awake intubation is not feasible,

securing the mass with an anchoring suture while awake is an alternative to avoid ball-valve upper airway obstruction, besides creating the surgical view.

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### Competing Interests

The authors declare no competing interests.

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