Unusual Complication With A Cohen Flexitip Endobronchial Blocker

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Citation

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Abstract

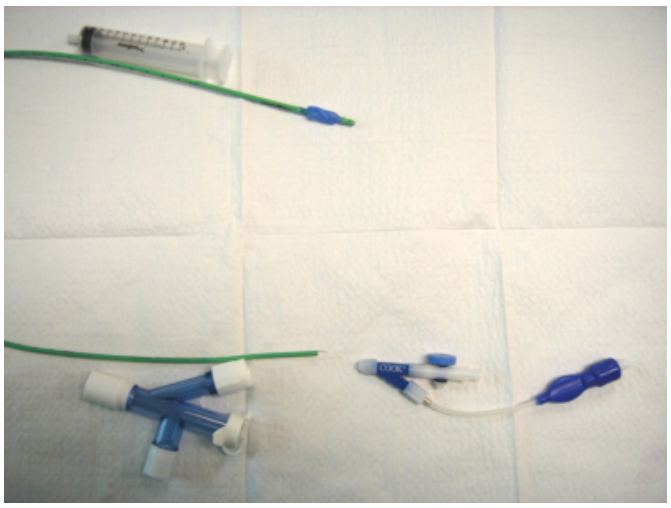
DEAR EDITOR

The above complication occurred while inserting Cohen Flexitip endobronchial blocker ([1]). The most important feature of the blocker is its flexible soft tip that allows to direct it in the desired bronchus. The blocker contains a lumen that allows suctioning of the lung to facilitate deflation, suctioning of secretion and insufflation of oxygen ([2]).

While attempting inserting the blocker through single lumen tube size 8mm in a patient undergoing lung resection, with tip deflection using the wheel on the proximal end, the blocker has separated from its wheel top (Figure 1).

Figure 1

Figure 1: Separated bronchial blocker lumen fro the controller



Besides many times while using the blocker, the wheel rotator became loose from the attached wire. The whole manipulation was without any vigorous tension. We believe that the weakest part of the blocker is the junction between the wheel proximal end and the blocker lumen tube, therefore we advice that gentle manipulation should be maintained during insertion of the blocker. Also we do advice single use of the wheel at the proximal end and avoid multiple usages. To the best of our knowledge this is the first case report on malfunctioned Cohen Flexitip Endobronchial Blocker.

References

1. Cohen E. The Cohen flexitip endobronchial blocker: an alternative to
a double lumen tube. Anesth Analg 2005;101:1877-9.

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