Rare Cases: Tracheal/bronchial Obstruction
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Citation

Abstract

HISTORY
A 75 year old female patient presents with shortness of breath. She has some cough with white and bloody sputum. Afebrile. She had a history of renal cell carcinoma with unilateral nephrectomy 30 years ago. Positive for hypertension, non-insulin-dependent diabetes mellitus and asymptomatic coronary artery disease. In the past year she underwent several bronchoscopies for evaluation of the airway. She had a known progressive narrowing of her distal trachea due to metastatic lung disease. Radiotherapy and chemotherapy did not improved her progressing disease. She was transferred to our hospital for further evaluation and possible palliative measures in regard to her airway.

ADMISSION
The patient presented with the following chest X-ray and chest CT scan:

Figure 1

Chest X-ray: atelectasis of the right lung with mediastinal shift to the right
Rare Cases: Tracheal/bronchial Obstruction

**Figure 2**
Chest CT scan: mediastinal mass (7 cm in diameter) compressing the trachea just above the carina

**Figure 3**
Chest CT scan: intratracheal/bronchial tumor mass obstructing the right mainstem bronchus

**Figure 4**
Close-up image of the intratracheal/bronchial tumor mass obstructing the right mainstem bronchus

**PLAN**
The patient's situation was desperate. The tumor mass had obliterated most of the right mainstem bronchus and was just about to start closing the left main bronchus. It was discussed with the patient, family, and referring physician that the thoracic team would attempt a palliative procedure to open the airway. The patient was intubated and ventilated in order to avoid respiratory failure. Sedation was obtained with a propofol drip. A DNR (Do Not Resuscitate) order was discussed and placed in order. Thoracic surgery and anesthesia discussed the plan of this high-risk procedure. The patient was taken to the operating room for fiberoptic bronchoscopy, YAG laser of the intratracheal/bronchial tumor mass and possible stent placement.

**INTRAOPERATIVE PROCEDURE**
Fiberoptic bronchoscopy and laser procedure through the endoscope

**Figure 6**

Fiberoptic bronchoscopy: tumor mass reaching into distal trachea and obstructing 98% of the right mainstem bronchus. Some bloody and necrotic tissue on the surface of the tumor mass

**Figure 7**

Laser in action: On the left upper corner carina with left mainstem bronchus (visible after several sessions of YAG laser). Active laser beam on the right upper corner treating the tumor mass
View from the distal trachea: open left mainstem bronchus in left upper corner. Carina in the middle and reopened right mainstem bronchus in the right lower corner with laser scars and burns.

One third of the tumor mass removed from the trachea with endoscopic forceps after YAG laser treatment.

**POSTOPERATIVE COURSE**

Uneventful postoperative course. Weaning from ventilator and extubation without problems on postoperative day 1. Patient discharged from intensive care unit with stable vital signs. Repeat of YAG laser surgery in the future possible as palliative procedure.

Postoperative chest X-ray prior to extubation on postoperative day: lungs bilaterally ventilated, large tumor mass in mediastinum/right upper lobe, mediastinum back in midline compare to preoperative image

1 weeks later: The patient is doing much better and is soon to be discharged.

Bronchoscopy reveals an open right mainstem bronchus.

**References**
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