Bronchospasm in a case of Ellis van Creveld syndrome in a patient posted for corrective osteotomy & elizarove surgery

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Citation

Abstract
Ellis-van Creveld syndrome (chondroectodermal or mesoectodermal dysplasia) is an autosomal recessive disorder. Initial reported as tetrad of clinical manifestations, including chondrodysplasia, postaxial polydactyly, ectodermal dysplasia, and congenital heart disease (CHD). Other involvement may occur in organs of endodermal origin, such as the pulmonary, renal, gastrointestinal, and central nervous systems. A known case of Ellis van Creveld syndrome was scheduled for elective corrective osteotomy and elizarove surgery. Here with we describe the clinical features of a patient and anaesthetic management of our patient

INTRODUCTION
Ellis-Van Creveld Syndrome or chondroectodermal dysplasia is a form of short-limbed dwarfism. The name chondroectodermal is used because it affects the skeleton (chondro) and the skin (ectoderm).1 The syndrome was first described by Ellis and Van Creveld2 in 1940. Reported incidence is one in 1500000.1 The highest frequency of Ellis–van Creveld syndrome is seen in one particular inbred population, the Old Order Amish community in Lancaster County, Pennsylvania, where the largest pedigree has been described (52 cases in 30 sib ships).3 Its incidence in India is very rare. Literature search from publication of first case in 1940 to date revealed only five case reports from this region.

CASE REPORT
A 12 year old child weighing 25 kg was posted for corrective osteotomy & elizarove surgery of tibia. Pre operative evaluation of the patient previous day showed spiky hair, high arched palate, syndactily, polydactyly, loss of lateral condyle of tibia, widened carpal bones, dwarfism and genu valgum.
Cardiac anomalies were ruled out by doing an echocardiogram. Lab values were Hb 11 gm%, blood sugar 101 mg/dl (random), blood urea 19 mg/dl, serum creatinine 0.9 mg/dl, serum sodium 140mEq/l, potassium 4.13meq/l. The patient was partially edentulous with cleft palate and.

Birth history showed normal delivery. There was no birth asphyxia or delayed milestones. Preoperatively patient was explained about the advantages of regional anaesthesia. But the patient accepted epidural catheter insertion only under general anaesthesia. The patient was given anaesthetic fitness under ASA class I. He was premedicated with Tab. Famotidine 10 mg previous day night and Tab. Famotidine 10mg and Tab. metoclopramide 5 mg on the morning of surgery. Once the patient was shifted to Operation theatre, 20 gauze I.V. line was secured on the left hand. Later ECG, NIBP and SpO2 monitors were connected. Base line readings on the table were pulse rate 68/min, blood pressure 100/60 mmHg, room air SpO2 100%. 40 µg of fentanyl intravenously and IV 0.5mg of midazolam premedication received on table. The patient was preoxygenated with 100% oxygen for 3 minutes and induced with inj. Thiopentone sodium 150 mg and paralysed with inj. Vecuronium bromide 3.2 mg intravenously. The patient was ventilated with mask with N2O and O2 (4 and 2 liters/min respectively) + isoflurane (1%) for 3 minutes. Intubated with no.6 cuffed endotracheal tube. Bilateral air entry was confirmed by auscultation and endotracheal tube was firmly secured. Later the patient was positioned in left lateral position and under aseptic conditions 20 gauze epidural catheter was inserted at L4 – L5 space to an intra epidural length of 4cm. Epidural catheter position at epidural space was confirmed by a test dose consisting of 3cc of 2% lignocaine with 15 µg of adrenaline. Patient was positioned supine and 6cc of 2% lignocaine was given through epidural catheter. Anaesthesia was maintained with N2O and O2 (2 and 1 liters/min respectively) + isoflurane (0.2 - 1%) + IPPV. Analgesia was maintained with 3cc boluses of 0.5% bupivacaine given through the epidural catheter every 60 minutes interval. The patient needed a total of 5 doses as the procedure was lasted for 6 hrs. Muscle relaxation was maintained with inj. vecuronium bromide top ups (0.4mg) as and when desired as determined by EtCO2. Throughout procedure the patient was monitored with ECG, SpO2, NIBP (every 5 minutes interval), EtCO2, end tidal agent monitoring (N2O, O2 and isoflurane), urine output and airway pressure. Total blood loss during the procedure was 300ml. Totally 1000ml of crystalloid 500ml of colloid and 200ml of packed cell was given. Total Urine output was 600ml. Last dose of bupivacaine was mixed with 3mg of morphine.

During the procedure two episodes of increase in airway pressure (from 16 cmH2O to 30 cm of H2O) was observed and on auscultation bilateral wheeze was appreciated along with drop in oxygen saturation to 92%. Bronchospasm was managed with nebulisation salbutamol. Inj. Hydrocortisone 50mg and inj. theophyline (at first episode) and by increasing isoflurane concentration (at second episode). Once procedure completed the patient was reversed with neostigmine (1.5mg) and atropine 0.9mg and extubated on table. Postoperatively analgesia was supplemented with the epidural morphine 3mg bolus as and when the patient demanded for 24 hrs (patient demanded 2 boluses). Post operative vitals were stable.

DISCUSSION

Richard W.B. Ellis of Edinburgh and Simon Van Creveld of Amsterdam first described Ellis-van Creveld (EVC) syndrome. They met in a train compartment while travelling to a paediatrics conference in England in the late 1930s, and discovered that each had a patient with the syndrome. Disproportionate dwarfism, postaxial polydactyly, ectodermal dysplasia, a small chest, and a high frequency of congenital heart defects (Table-1) characterize this autosomal recessive syndrome. Pathophysiology is unknown. Recently two EVC genes were identified. This may through some light on pathophysiology in future. Morbidity and mortality is related to the thoracic dysplasia, respiratory insufficiency and cardiac anomalies. This leads to death in infancy in 50% of patients. Frequency is equal in both sexes.
The clinical features that are suggestive of Ellis van creveld syndrome in our patient are spiky hair, high arched palate, syndactily, polydactyly, loss of lateral condyle in the tibia, widened carpal bones, dwarfism, partially edentulous & genu valgum. There are no cardiac anomalies which were ruled out by doing echocardiogram of heart. Literature says that cardiac anomalies may be present only in 50% of cases1. Total height of our patient is 104 cm. For a child who is 12 yrs old this height is very less.

As the patient was anxious and as it was a prolonged procedure we had chosen for a combined procedure i.e. combined epidural and general anaesthesia. During the procedure twice we had encountered bronchospasm. It might be due to patients’ intrinsic problem because of the syndrome (small chest, recurrent infection, and restrictive lung disease) which was not obvious when the patient was conscious, but which was encountered during anaesthesia.

CONCLUSION

Though cardiovascular problem which is present in 50-60% of cases with Ellis-Van Creveld Syndrome is the major concert of anaesthetic management (which is not so in this case), respiratory problems like small narrow chest, restrictive lung disease, recurrent infection, pneumonia, lobar emphysema are also major part of anaesthetic management. Preoperative evaluation for Ellis-Van Creveld Syndrome should also include Chest X-ray, CT-scan chest, and pulmonary function test to rule out restrictive lungs disease.

References

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