

Anaesthetic Management Of A Child With Arthrogriposis Multiplex Congenita

M Inal, G Kaya, Z Pamukcu

Citation

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Abstract

Arthrogriposis multiplex congenita is a rare disease characterized by micrognathia, limited mandibular opening and multiple joint contractures. Difficult airway due to micrognathia and limited mandibular opening may complicate anaesthetic management in this syndrome. We describe the anaesthetic management of a child with arthrogriposis multiplex congenita syndrome undergoing repair of club feet.

INTRODUCTION

Arthrogriposis multiplex congenita is an uncommon condition characterized by multiple joint contractures⁽¹⁾. Although most contractures involve the extremities, patients with arthrogriposis multiplex congenita can have maxillofacial involvement including limited mandibular opening from temporomandibular joint involvement and microstomia^(2,3).

Arthrogriposis multiplex congenita also effected other organ systems such as cardiovascular, respiratory, gastrointestinal, genitourinary and locomotor system⁽⁴⁾. The incidence of this syndrom is 1 per 3000-10000 live births ^(1,2).

Patients with arthrogriposis multiplex congenita frequently require anesthetic care during surgical procedures to correct the orthopedic deformities or the organ systems associate with the disease process. Given the multiple organ system involvement of the arthrogriposis multiplex congenita, the potantiel for difficulties with airway management as well as the implications of the underlying neuromuscular disorder, several perioperative concerns must be addressed in these patients ⁽⁴⁾.

We reviewed our perioperative experience of a child with arthrogriposis multiplex congenita.

CASE REPORT

A 9-month-old 20 kg female infant presented for repair of club feet. The birth history revealed that the infant was born at term. She had multiple contractures so that a diagnosis of artrogriposis multiplex congenita was made when she was 3-

months-old.

She underwent multiple previous surgeries such as repair of club feet and release of tendons. Physical examination revealed an awake infant with severe multiple joint contractures involving all limbs and marked micrognathia.

After monitorization of the patient with three way ECG, SpO₂ and NIBP, a 24-gauge scalp peripheral intravenous catheter was secured. After 5 minutes of preoxygenation, anesthesia was induced by propofol (2.5 mg kg⁻¹) and fentanyl (1 µg kg⁻¹). Mask ventilation was attempted without difficulty. After neuromuscular block with mivacurium (0.2 mg kg⁻¹) laryngoscopy was performed. The laryngoscopic grade according to Cormarc Lehane grade was ???; the epiglottis could be visualized but the glottic orifis could not. The first intubation attempt was unsuccessful. Following a further failed intubation attempt, at the third attempt a size 3 uncuffed orotracheal tube inserted into the trachea. Immediately after the insertion, positioning was confirmed by breath sounds. Although intubation had been difficult, the patient did not become hypoxic at any stage. Maintenance of anesthesia consisted of sevoflurane supplemented with fentanyl. At the end of 1.5 hours of anesthesia she awaked and was extubated without complications.

DISCUSSION

This case report describes general anesthesia in a child with arthrogriposis multiplex congenita and highlights a number of potential anesthetic problems. The primary concern to the anesthesiologist is the potential for airway involvement thereby making direct laryngoscopy and endotracheal

intubation difficult (2,3,4,5).

The most common maxillofacial findings are decreased mandibular opening, micrognathia, a high arched palate, deficient musculature of the orofaringeal complex, limited tongue protrusion, cleft palate, Pierre-Robin like sequence, short neck, torticollis and hemangiomas of the upper face (3,4,5,6). Steinberg et al. reviewed the findings in 23 patients with arthrogriposis multiplex congenita and noted a 22 % incidence of maxillofacial involvement with limited mouth opening in three of the 23 patients (3). Martin et al. reviewed 25 % incidence of maxillofacial involvement with limited mouth opening in three of the 12 patients (6).

In our case the patient had a limited mouth opening, micrognathia and a short neck. The laryngoscopy was difficult and we intubated the patient in the third attempt.

The limited mouth opening in patients with arthrogriposis multiplex congenita can be severe and may make direct laryngoscopy impossible (2,3,4,5). Thomas et al. reported a 3 year old patient with arthrogriposis multiplex congenita who presented for TMJ surgery whose initial maximum interincisal opening was only 9 mm (5). In our case the child has a limited mouth opening with an interincisal opening only 10 mm.

The patients with arthrogriposis multiplex congenita may be more susceptible to the respiratory depressant effects of various intravenous and inhalation anaesthetics (1,2,4). Respiratory problems in intraoperative period and postoperative period may be related to associated myopathy, pulmonary hypoplasia and spine deformities (1,4,6). In our case we noted nothing about postoperative atelectasis or a restrictive respiratory pattern, but we would suggest close monitoring for postoperative respiratory function.

Baires et al. reviewed 396 anaesthetic agents in 67 patients with arthrogriposis multiplex congenita and found no episodes of MH with exposure to known triggering agents (7). In our case we are not noted intraoperative hyperthermia.

The choice of neuromuscular agent is also important in patients with arthrogriposis multiplex congenita. In patients

with an identified underlying myopathic disorder, there may be an exaggerated hyperkalemic response and there may be a caution to the use of succinylcholine (7).

As sensitivity to nondepolarizing neuromuscular blocking agents has been reported in patients with underlying neurologic and myopathic conditions, our preference was the use of a short acting relaxant such as mivacurium (8,9,10).

In summary, this report highlights the anaesthetic management of arthrogriposis multiplex congenita, which may be complicated by a difficult airway because of micrognathia. Appropriate preoperative evaluation and preparation is required.

CORRESPONDENCE TO

Mehmet Turan Inal Trakya University Faculty of Medicine
Department of Anaesthesiology 22030 Edirne, Turkey
Tel:+902842357641 Fax:+902842358096 e-mail:
mehmetturainal@yahoo.com

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Author Information

Mehmet Turan Inal, M.D.

Consultant, Department of Anesthesiology and Reanimation, Trakya Univercity Faculty of Medicine

Gaye Kaya, M.D.

Asis. Prof., Department of Anesthesiology and Reanimation, Trakya Univercity Faculty of Medicine

Zafer Pamukcu, M.D.

Professor, Department of Anesthesiology and Reanimation, Trakya Univercity Faculty of Medicine