**NOTE 3**

**PATIENT 1005**

**DATE: 5/11/20**

**OTOLARYNGOLOGY OPERATIVE REPORT**

**Date of Procedure:  5/11/20**

**Pre-Procedure Diagnosis:**

**1. Respiratory failure**

**2. Failure to extubate**

**3. History of prematurity**

**4. Bronchopulmonary dysplasia**

**Post Procedure Diagnosis: Same**

**Procedure:**

**1. Direct laryngoscopy**

**2. Rigid tracheobronchoscopy**

**Surgeon: Dr. Rachel Ramel, DMD, MD**

**Assistant:**

**1. Kathy K, MD, ORL Fellow PGY6**

**2. Paul Atwell, MD PGY3**

**Anesthesia:  General inhalational anesthesia with spontaneous ventilation**

**Specimens: none**

**Estimated Blood Loss: Minimal.**

**Complications: none**

**Indications: Patient is an 82 day old male who was born at 24 weeks with ventilator dependence, bronchopulmonary dysplasia, and failure to extubate. After a thorough discussion of the risks, benefits, and alternatives of surgery with the patient's parents, the decision was made to proceed with surgical intervention.**

**Laryngeal Exposure:**

**Exposure of Larynx: Grade 1 with a size 8 cm slotted Storz laryngoscope**

**Patient position and/or special maneuvers:  Flat**

**Findings:**

**1) Supraglottis: within normal limits. Evaluate for a laryngeal cleft was not performed**

**2) Glottis: Mobility was not assessed; however, the glottis was widely patent without masses or lesions**

**3) Subglottis: Widely patent without masses or lesions**

**4) Upper trachea: Normal**

**5) Mid-trachea: Normal**

**6) Lower trachea: Normal**

**7) Right bronchus: Normal**

**8) Left bronchus: Normal**

**9) Airway size: 3.0 uncuffed endotracheal tube**

**Emergency Airway Classification:**

**Bag / Mask from above:             Did not attempt**

**LMA from above:                       Did not attempt**

**Able to intubate from above:      Yes**

---------------------------------------------------------------------------------------------------------------------

**Tracheostomy is only airway:     No**

**Description of Procedure:  The patient was taken to the main operating room, and placed in a supine position on the operating table.  The patient's eyes were protected.  The surgical timeout was performed. The patient was already intubated with 2.0 uncuffed endotracheal tube. A Storz Benjamin pediatric side-slotted laryngoscope was used to expose the patient's larynx.  An endotracheal tube was placed in the patient's hypopharynx, and used to insufflate oxygen during the exam, in order to maintain adequate oxygenation.  The patient was allowed to breathe spontaneously. 0.5 mL of 1% lidocaine was sprayed onto the vocal folds.  A neonatal 1.9 mm telescope was used to fully evaluate the patient's larynx, including evaluation of the subglottis. The findings as detailed above were noted, and documented with intra-operative photos.**

**Upon completion of the diagnostic laryngoscopy, a complete rigid bronchoscopy was performed.  The Hopkins II telescope was used to evaluate the patient's subglottis, upper, mid, and distal trachea.  The right and left bronchi, as well as take-off of segmental bronchi were evaluated.  The findings were noted, as detailed above, and documented with intra-operative photos. The patient was then reintubated with an uncuffed 3.0 endotracheal tube. There was some resistance with advancing the tube into the trachea. Also, there was no leak at 30 cm of water.**

**The patient's care was then transitioned to the pulmonology service for their flexible bronchoscopy.**

**Dr. Rachel Ramel was present and participated for the entire procedure. All sponge and needle counts were correct at the end of the case.**

Rachel Ramel, DMD, MD