



# Aspiration of a Fractured Tracheostomy Tube Managed by a Rigid Bronchoscopy via Tracheostomy Stoma in a Patient with Existing Airway Compromise

**Alhad Mulkalwar\***; Sameer Rege

Intern, Seth GS Medical College and KEM Hospital, Mumbai, India.

**\*Corresponding Author(s): Alhad Mulkalwar**

Intern, Seth GS Medical College and KEM Hospital,  
Mumbai, India.

Tel: +91-9869178040;

Email: drsamrege@gmail.com

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## Clinical Image description

A 53-year-old asymptomatic male presented with a fracture and aspiration of his polyvinyl chloride (portex) tracheostomy tube, diagnosed on X-ray (Figure 1) and CT scan (Figure 2). A therapeutic transoral bronchoscopy was not possible due to glottic carcinoma. The foreign body was removed under sedation using a rigid bronchoscope introduced through the tracheostomy stoma. The 8 cm long fractured piece of tracheostomy tube was removed in toto (Figure 3) without any complications and the patient had an uneventful postoperative recovery.

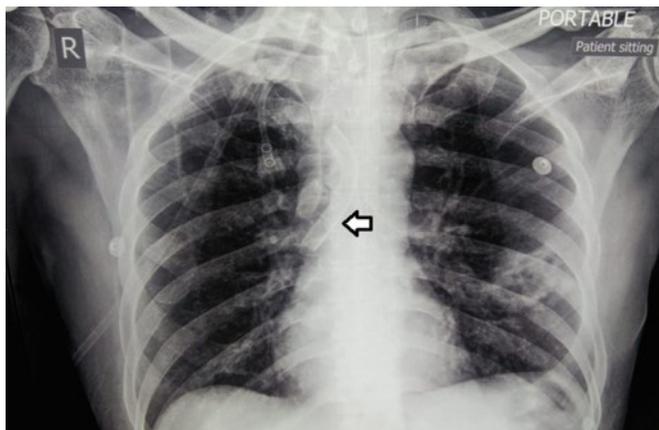
A foreign body lodged in airway requires emergent attention due to the inherent risk of airway compromise which could be potentially life threatening. Thus, it would be prudent to perform close checks on patients with tracheostomy tubes on follow-up to identify pending failure and change the tube every 8 weeks. In incidentally diagnosed asymptomatic cases of foreign body aspiration, its prolonged stay bronchial tree can lead to irreversible pulmonary changes due to mechanical pressure effects, granuloma formation, chemical reactions and at



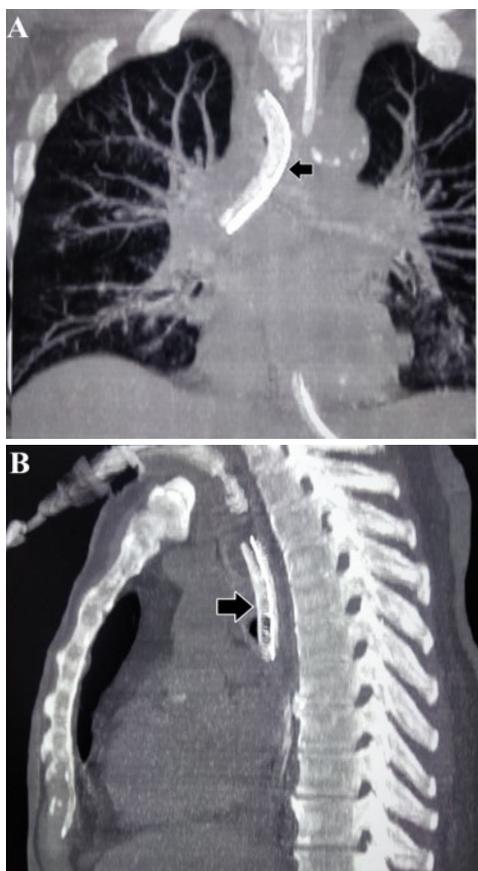
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times can lead to even malignant transformation, increasing the risk of bleeding during removal, thus, warranting extra caution. Anesthetic management during the removal of fractured tracheostomy tube is challenging. Most of these patients will be having a compromised airway anatomy because of the primary disease process and fracture, and dislodgment of the tube may lead to life-threatening airway obstruction. In the present case scenario, the patient already had glottic carcinoma with resulting airway compromise.

Published reports of a fractured tracheostomy tube presenting as a foreign body in the tracheobronchial tree are few [1-4] and those managed by a bronchoscopy performed via the tracheostomy stoma in a patient of pre-existing airway compromise are even rarer.



**Figure 1:** Chest X-ray (poster-anterior view) showing fragment of tracheostomy tube in right main bronchus.



**Figure 2:** CT scan of chest: A – coronal view and B – sagittal view showing fragment of tracheostomy tube in right main bronchus.



**Figure 3:** Retrieved fractured fragment of tracheostomy tube (8 cm long) which was found to be broken at the junction of shaft and neck plate.

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