Research Article

A Case of Ingested Laryngoscope Bulb During Emergency Endotracheal Intubation

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Article history:

Submission December 2020

Revised December 2020

Accepted December 2020

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ABSTRACT

Laryngoscope is one of the most important lifesaving tools in the armamentarium of medical personnel. As is the case with any other tool, this too is susceptible to rare failures. One of these rare malfunctions is the dislodgement of bulb during endotracheal intubation. This can be associated with serious consequences if patient aspirates or ingests the bulb. In the following communication we report this off chance mishap while intubating a patient in trauma ICU.

Keywords: Laryngoscope, endotracheal intubation, X-rays.

Case Report

A 55 years male presented with intracranial hematoma for which he was operated and craniotomy was done with evacuation of hematoma. In the postoperative period, patient's GCS score dipped and emergency endotracheal intubation under direct laryngoscopy was attempted to protect his airway. During the procedure light source of the laryngoscope became nonfunctional. On inspection, the scope's light bulb had dislodged and could not be located in the surroundings. Immediately the patient was intubated with help of a different laryngoscope. On exploration of the oropharynx and hypopharynx, bulb was nowhere to be found. Neck, chest and abdominal X-Rays showed laryngoscope bulb inside the stomach of the patient [Fig 1 and 2]. Gastroenterologist's opinion was sought and patient was managed conservatively. Repeated x-rays were done and patient was put on high bulk diet such as banana. After 4 days, the laryngoscope bulb was retrieved

from the stool of the patient. The patient was eventually discharged after full recovery.

Discussion

Airway management in critical care is difficult and more likely to be associated with complications. Few cases have been reported in which the bulb or other part of a laryngoscope was aspirated or swallowed. Ince *et al.* and Naumovski *et al.* reported ingestion of laryngoscope bulb in neonates (Ince *et al.*, 1998)(Naumovski *et al.*, 1991). Thapa *et al.* reported a case of lost laryngoscope bulb in a neurology patient during endotracheal intubation (Thapa *et al.*, 2010). Sklar and Tandberg reported a case of ingestion of broken glass in patient with seizure (Sklar & Tandberg, 1992).

Conclusion

This case is another example that signifies the importance of proper checking of the integrity of airway equipment both before and after

How to cite:

Sharman, S., Gupta, S., Nagyan, T., Nasar, Md. A., Some, S. & Agarwal, PN. (2020). A Case of Ingested Laryngoscope Bulb During Emergency Endotracheal Intubation. *Indonesian Journal of Medical Sciences and Public Health*. 1 (2), 51 – 53. doi: 10.11594/ijmp.01.02.04

its use. We are fortunate in that the incident was recognized immediately and the laryngoscope bulb was swallowed rather than aspirated. X-ray of the neck, chest and abdomen should be taken if the lost bulb cannot be found

in the oral cavity. It is important to have inspection of this equipment at periodic intervals. This incident also signifies the importance of the availability of second laryngoscope in cases of emergency intubation

Figure 1. X-ray abdomen showing the laryngoscope bulb inside the stomach

Figure 2. X-ray abdomen showing laryngoscope bulb in ascending colon

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