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Be prepared and think out of the box!

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CASE REPORT

• A 72-year-old woman was referred to the emergency department (ED) after a dental procedure. The patient was displaying a swelling and ecchymosis of the tongue and pharynx. She was tachycardic (127 beats per minute (bpm)) and tachypnoeic (40 breaths per minute (bpm)).

The past medical history was positive for atrial fibrillation and arterial hypertension treated with warfarin and bisoprolol. The morning of her admission, she had dental implants performed by a maxillofacial surgeon. A few hours later, she experienced breathing problems. On admission, the patient's vital signs were: blood pressure (BP) 160/95 mmHg, heart rate (HR) 127 bpm and a respiratory rate (RR) 40 bpm; oxygen saturation (sat) 94% on room air. She was orientated but agitated. The inspection of the oral cavity displayed a swelling and ecchymosis of the tongue and oropharynx. Because of the procedure and the potential medication used an allergic reaction to drugs was suspected and treated accordingly.

Patient's evolution deteriorated. She displayed a hypoxic status with difficulties to breathe and drops in pulse-oximetry despite oxygen administration via a non-rebreathing mask.

(BP 110/65 mmHg, HR 135 bpm, RR 45 bpm, sat 86%; more agitated and disorientated).

First a mask and bag ventilation were used while she was conscious. When she became unconscious and apnoeic, an endotracheal intubation was attempted and remained unsuccessful (three attempts), as was the gum-elastic boogie. Ultimately, we placed a laryngeal mask but due to high inspiratory pressures, the inability to seal the airway and ongoing desaturation, an emergent percutaneous tracheostomy was performed. A fiberoptic intubation was not attempted due to its unavailability

The overall complication associated with teeth procedure is 7-10% and the risk of haemorrhage is 0.2% (1). Bleeding complication in patients receiving warfarin is 11,4 % (2).

Airway complication is rare after teeth procedures. A review of literature revealed one fatal case secondary to hematoma (3).

In our case the haemorrhage was secondary to direct injury to the lingual artery and aggravated by warfarin treatment.

Other causes that might explain these symptoms such as pulmonary embolism, chronic obstructive pulmonary disease, asthma attack, pneumothorax, hemothorax, pneumonia were also considered.
But allergic reaction to drug was the main focus.
An intraoral examination would allow identification of the bleeding.
The patient was successfully weaned from the ventilator and discharged from the ICU 5 days after and discharged from the hospital after another 5 days .

Emergency physicians (EP's) should be able to manage and anticipate a ''can't ventilate-can't oxygenate'' situation. Difficult airway management training should be basic content of the EP's curriculum.

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