

A New Anesthesia Method for Montgomery T-tube Tracheal Stent Implantation

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Background

The Montgomery T-tube tracheal stent(Montgomery Ttube) is often used to treat subglottic stenosis, and the general anesthesia carried out by an anesthesiologist and the rigid bronchoscopy performed by an endoscopist are required for the placement of Montgomery T-tube. However, this way is not suitable for all types of patients. **Case presentation**

Conclusions

Intravenous induction of conscious sedation combined with NFNC could help

Here, we describe a patient with cervical spinal cord injury and incomplete paraplegia who was successfully implanted with Montgomery T-tube for subglottic stenosis after intravenous induction of conscious sedation combined with high-flow nasal cannula oxygen(NFHC) and expect to provide a reference for the treatment of these patients. with Montgomery T-tube Implantation and the treatment of patients in this particular situation. However, more data are needed to support the use of this anesthesia method.

Conflicts of Interest

None of the authors have potential conflicts of interest to declare.

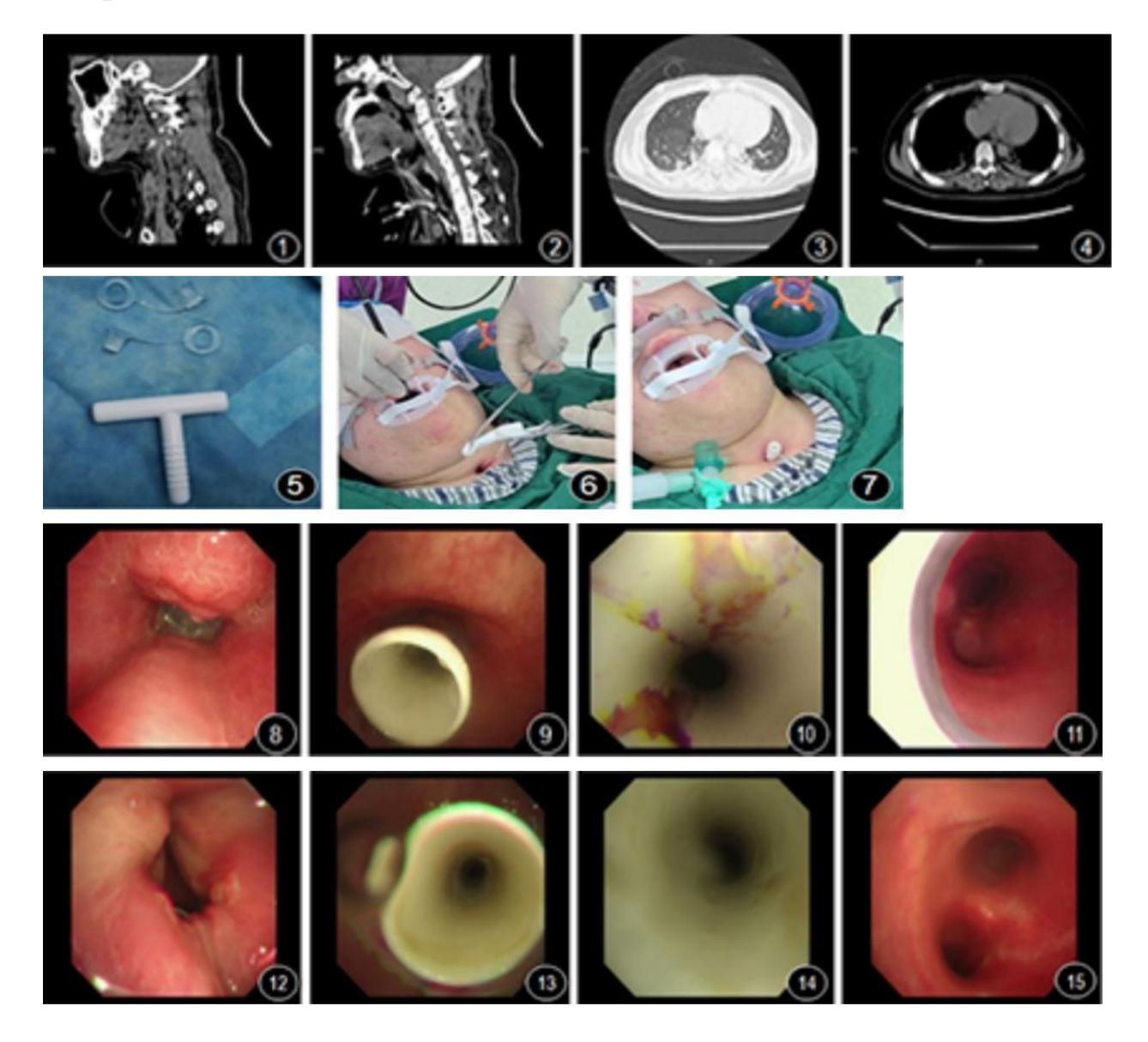


Figure 1-4: The findings of neck and chest CT of this patient.

Figure 5-7: Montgomery T-tube(Figure 5). The process of Montgomery T-tube placement by the fiberoptic bronchoscopy and HFNC (Figure 6-7).

Figure 8-11: Stenosis due to the hyperplasia of granulation tissue and mucosal hypertrophy above the tracheostomy tube was found in a bronchoscopy. The rate of stenosis was 60% and the degree of stenosis was grade II(Myer-Cotton grade)(Figure 8). The manifestation of successful placement of the Montgomery T-tube in the bronchoscopy(Figure 9-11).

Figure 12-15: The stent was in good position at 1 centimeter below the glottis in a bronchoscopy after 2 months(Figure 12). Upper end of Montgomery T-tube(Figure 13). The inner part of the Montgomery T-tube(Figure 14). The lower end of the Montgomery T-tube(Figure 15).