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Acute Onset Macroglossia After Traumatic Intubation

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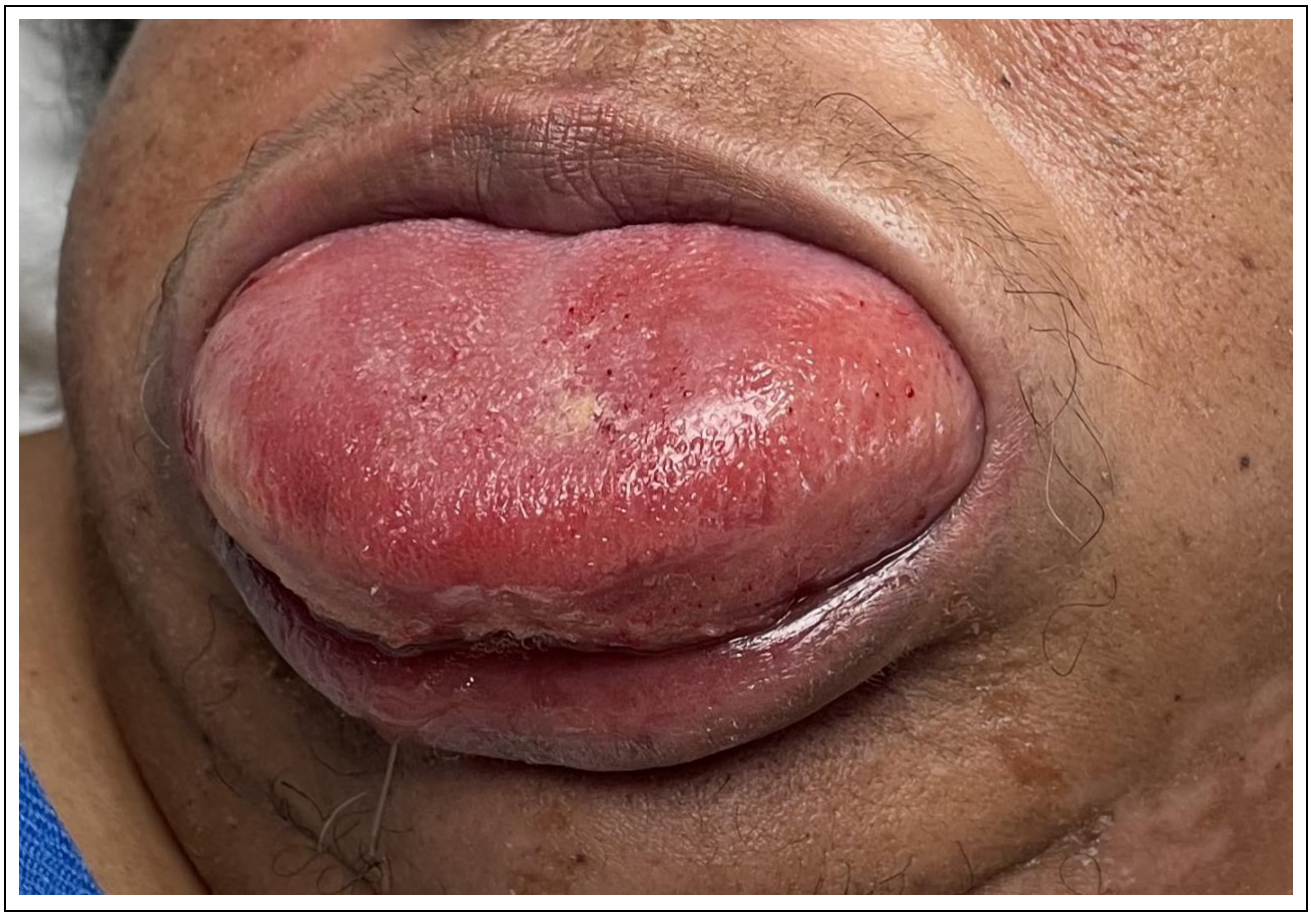

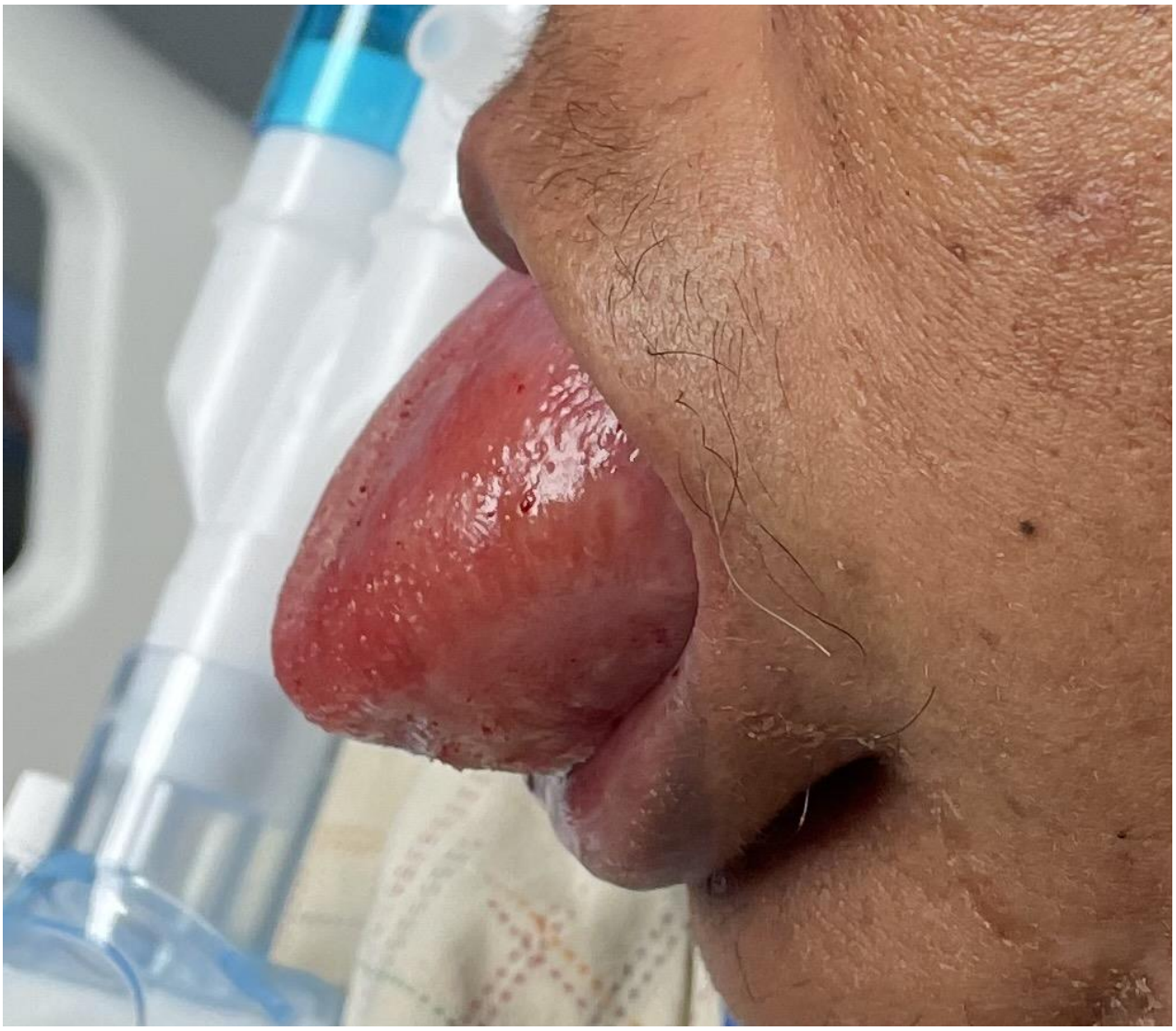

Clinical Image

A 56-year-old female with a past medical history of COPD presented with complaints of shortness of breath for the past 1 week. On vitals respiratory rate was 24 bpm, saturating 95% on BiPAP with 40% FiO2. Decrease air entry was noted with wheeze bilaterally on examination. ABG showed a pH 7.156, pCO2 104.8, pO2 90 on 60% FiO2. Patient was admitted to the ICU for acute hypercapnic respiratory failure in the setting of COPD exacerbation and was intubated. The intubation was difficult with 3 failed attempts due to hypertrophic airway. She developed acute respiratory distress syndrome in the ICU with increased oxygen requirements. Due to persistent hypoxemia despite full ventilatory support, prone positioning was utilized for a period of 16 hours per day for 3 days. Her tongue was noted to be progressively more swollen with protrusion out of the oral cavity on the 8th day post intubation. On examination up to 3 inches of bilateral symmetrical enlargement of the tongue was seen. Nasopharyngeal and oropharyngeal obstruction was seen. The tongue was viable with good capillary refill and no necrosis. The patient had no history of allergies and no evidence of acute infection or trauma.

Her C1 esterase and Thyroid Stimulating Hormone (TSH) levels were normal. CT scan showed bilateral enlargement of tongue with obliteration of vallecula secondary to lingual enlargement. No evidence of mass or drainable fluid collection was seen on CT scan. The parotid and submandibular glands were unremarkable. No pathological lymphadenopathy or superior vena cava (SVC) obstruction was observed. Steroid therapy for COPD exacerbation did not decrease the tongue swelling. Symptomatic treatment was advised by an otorhinolaryngologist with cold compressors and ice for the viable tongue. She was treated with lingual compressive wraps and her symptoms improved after a few weeks.