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An Interesting Case of Anesthesia Mumps in Sawangi, Wardha

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ABSTRACT

Intense transient parotid organ expansion in relationship with general anaesthesia is an uncommon entanglement and complication and has likewise been called anesthesia mumps. Unilateral or bilateral parotid or submandibular expanding generally arises during a surgical procedure under anaesthesia or, a couple of hours after the fact and as a rule settle in a couple of days with no sequelae. It has been accounted for as a difficulty and complication after general anesthesia in patients going through surgical procedures in prone and lateral decubitus position, even after caesarean section in the supine position. We present an instance of a bilateral parotid enlarging saw in quick postoperative course, in a patient who underwent open anatropic pyelolithotomy (right side) for stag horn calculus.

Key words: Mumps, Anaesthesia, Glands, Positioning, Swelling

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INTRODUCTION

Anesthesia mumps is characterized by an acute transient parotid gland swelling in association with general anesthesia [1]. It is a rare, but known entity that resolves spontaneously in some days without any complication [2]. It has been found to be associated with patients of all age groups and various surgical procedures. Majority of the cases were found after the patient underwent general anesthesia for a long time [3]. We present this case, as no case of anesthesia mumps, has been reported yet in Sawangi, Wardha (Maharashtra).

CASE REPORT

A 41-year-old, 76 kg man scheduled for open pyelolithotomy (right side) for stag horn calculus, under general anesthesia. His past medical history revealed no specific findings. The preoperative results of biochemical studies, chest X-ray and electrocardiography (ECG), were normal. Physical examination and airway examination were within normal limit. General anesthesia was induced with intravenous Propofol 2 mg/kg, Fentanyl citrate 1 mcg/kg, Atracurium 0.5 mg/kg and maintained with isoflurane/oxygen/nitrous oxide mixture under standard monitoring. After oral tracheal intubation, an endotracheal tube was fixed on the right side of the mouth and kept at 20 cm in depth. After intubation, the patient was placed in the left lateral position with the neck turned to the left side, and the left side of the face was placed on a soft gel rolling pad. The surgery proceeded for about 4 hours. The total blood loss was about 350 ml. After endotracheal extubation, patient was shifted to post-anesthesia care unit, where swelling of the bilateral parotid gland was noted. The swelling of the parotid gland increased in size and hardness and patient complained of mild pain. ENT consultation was done and examination revealed firm, mildly erythematous swelling starting from the per-auricular face (bilaterally) to the angle of the mandible, no parotid secretions noted. Patient was reassured, and pain was managed with non-steroidal anti-inflammatory drugs. Patient was discharged to home at 7th postoperative day after complete recovery with a follow-up visit at ENT clinic.

DISCUSSION AND CONCLUSION

Anesthesia mumps is an acute transient sialadenitis of the major salivary glands in the early postoperative period [1]. It is a rare, but known complication of general anesthesia; it is usually unilateral, transient swelling of the parotid gland which may last for several minutes to several days, resolving spontaneously without requiring any specific treatment [2]. It has been reported in a wide range of age groups and in different surgical procedures [3]. The majority of cases were found after the patient who underwent anesthesia for a long time [4]. Incidence

of anesthesia mumps was reported that 5 in 3000 following endotracheal anesthesia by Matsuki, et al. [5].

The etiology and the mechanism behind the anesthesia mumps are still not clear. Among the implicated mechanisms suggested in literature are trauma, head and neck positioning, straining and coughing during anesthesia, vascular congestion and venous engorgement of head and neck. overactive pharyngeal reflex stimulation of the salivary gland via the parasympathetic nerves, succinylcholine-stimulated copious secretions [1], dehydration, and mechanical blockage of the parotid duct by intubation and fixation of the endotracheal tube or head stripping and obstruction of glandular excretory ducts by position, calculi, or thickened secretion [6] were the major causes of acute salivary glands enlargement during induction of anesthesia.

Liu, et al. [1] believe the presence of the patient's underlying disease (obesity), choice of anesthetic drugs (succinylcholine, atropine), surgical position (prone, lateral decubitus), operative site (such as head and neck surgery) and induction methods (such as endotracheal tube, laryngeal mask inadequate insertion and fixation) may all contribute to the development of acute swelling of the parotid glands after general anesthesia. In our patient, prone positioning, endotracheal intubation and prolong surgery may be the contributing factors to the development of acute unilateral transient swelling of the parotid gland.

Anesthesia mumps is uncommon postoperative complication but, fortunately, it is commonly self-limited condition, which rapidly improves with symptomatic therapy. Symptomatic therapy includes reassurance, observation, rehydration therapy and anti-inflammatory drugs such as Nonsteroidal anti-inflammatory drugs [1,7]; dehydration is one of the most common causes of anesthesia mumps. Therefore, adequate rehydration therapy is fundamental for the treatment of anesthesia mumps [1,7]. Our patient was treated with Nonsteroidal anti-inflammatory drugs, and the swelling subsided gradually within a week.

To prevent this complication, we suggest the use of an adaptive shaped soft pad for proper padding of face, to avoid direct compression of the parotid gland and ducts. Minimum turning of neck should be allowed to keep normal venous blood circulation, especially when the patient is placed in the prone position, or the duration of surgery is long. Premedication with anticholinergic drugs to decrease secretions, smooth intubation and extubation without disturbance or straining of the patient to avoid mechanical stimulation and occurrence of this unusual complication. Moreover, keeping an optimum hydration status during surgery is another important point in the prevention of this complication. In conclusion, proper use of anesthetic medication and technique, with adequate patient protection may help decrease this complication.

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