

Severe subcutaneous emphysema in a term neonate

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DESCRIPTION

The baby was born by elective caesarean section because of breech presentation, at 38+6 weeks of gestation with an Apgar score of 9 at 1 min, 9 at 5 min and a birth weight of 4.02 kg. She was noted to be grunting at 20 min of age and had O₂ saturations of 55% in air and therefore commenced on O₂ by face mask initially, followed by continuous positive airway pressure (CPAP) at a pressure of 5 cm as O₂ requirements remained high (up to 60%). CPAP pressure did not need to be increased further as the O₂ requirement came down to 40% and remained between 30% and 40% for the subsequent 24 hours. Initial capillary blood gas at 2 hours of age (on CPAP 5 cm, FiO₂ 0.35) showed: pH 7.28; pCO₂ 7.05; pO₂ 7.15 and BE -2. Repeat capillary blood gas at 4 hours (on CPAP 5 cm, FiO₂ 0.35) showed: pH 7.30; pCO₂ 6.95; pO₂ 5.63; BE -2.

She developed a sudden-onset swelling of the anterior chest wall and neck at 24 hours of age with palpable crepitus and chest X-ray showed gross subcutaneous emphysema over the upper chest wall and neck, with bilateral pneumothoraces and air in the mediastinum (figure 1). The chest X-ray taken at 4 hours of age was unremarkable. The baby was then intubated, commenced on conventional ventilation, sedated and paralysed, and she settled quickly in 30%–40% O₂ on peak inspiratory

pressure of 20–22 cm. She also had a chest drain inserted on the right side for 24 hours and was extubated a further 24 hours later. She had a normal echocardiogram and barium study with no evidence of oesophageal perforation. A chest X-ray on day 10 of life showed almost complete resolution of subcutaneous air and the baby was discharged on day 12 of life.

Subcutaneous emphysema is a rare complication in newborns occurring secondary to pneumothorax and pneumomediastinum. The latter communicates with several anatomical structures outside the chest including the submandibular space, retropharyngeal space and the vascular sheath in the neck along which air can track under pressure.¹ Conservative management normally suffices until the source of air leak closes,² and the air in subcutaneous tissue gets absorbed spontaneously unless it is secondary to traumatic rupture of the trachea after a difficult intubation,³ when it can have high morbidity and mortality rates due to cardiac tamponade and will need aggressive treatment.

Learning points

- ▶ Subcutaneous emphysema fortunately is a very rare complication in newborn babies as compared to older children, even though air leak syndromes like pneumothoraces and pneumomediastinum are fairly common.
- ▶ Any type of mechanical ventilation including continuous positive airway pressure and intermittent positive pressure ventilation during resuscitation can lead to this serious complication and conservative treatment normally suffices until the air leak closes.
- ▶ Close monitoring is needed in all babies in case the air leak is secondary to tracheal rupture due to a difficult intubation; then it carries high morbidity and mortality due to cardiac tamponade which needs aggressive treatment.

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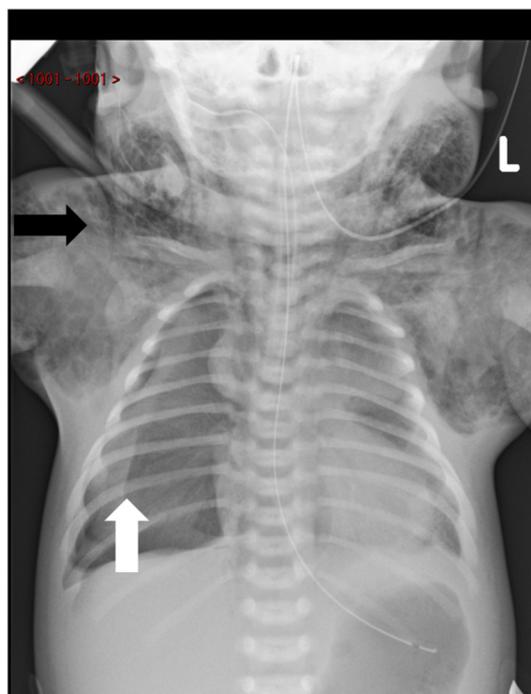


Figure 1 Chest X-ray showing mediastinal air, subcutaneous emphysema (black arrow) and pneumothorax (white arrow).



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