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Answer: Iatrogenic mediastinal haematoma

Examination revealed an anterior diffuse neck swelling extending from the chin down to the nipple line. There was also subcutaneous emphysema and the trachea was not palpable. In this case, the haematoma was due to bleeding from the right sternocleidomastoid. Bleeding controlled with diathermy and ligations. Tracheostomy tube inserted after the active bleeding secured.

Tracheostomy is a common procedure and is commonly performed by trained surgeon, in particular otolaryngologists (two-thirds of the cases). [1] The indications for tracheostomy include prolonged endotracheal intubation, for ease of tracheobronchial toileting and to bypass the upper airway obstruction in cases of oropharyngeal or laryngeal tumours.

Bleeding is the most common early complication of tracheostomy and most can be managed intra-operatively with no sequelae. Tracheostomy in the elective setting is associated with very low risk. [3] Even in the emergency setting, the rate of perioperative bleeding is low.

During tracheostomy, the trachea is usually encountered without difficulty if the exact plane is identified. The operative field is supposed to be bloodless. In a bedside tracheostomy, there is a tendency for the surgeon to perform the incision more towards him. A bed on the ward is wider than the operating table, and this can lead to difficultly in the positioning of the unconscious patient. Nevertheless, proper positioning, instruments and adequate lighting need to be applied in whatever condition a tracheostomy needs to be performed. Meticulous surgical technique by well-trained personnel is the most important factor in this common but individualised procedure.

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