

# Selection Type Of Bronchoscopy used in Different Preoperative Conditions

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## Commentary

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## DESCRIPTION

Bronchoscopy is invaluable as a diagnostic and therapeutic tool in the intensive care unit. Bronchoscopy has been used to facilitate intubation evaluate the airway, change endotracheal tubes and evaluate causes of stridor in the immediate postextubation period. Bronchoscopy may also be used for diagnostic purposes in patients with persistent infiltrates or hemoptysis. Recent cardiac events are only a relative contraindication to bronchoscopy.

### Virtual bronchoscopy

It's a conventional CT and bronchoscopy are routinely used to evaluate patients with suspected endobronchial or peripheral pulmonary diseases. Conventional CT is limited in detecting central airway lesions. Currently, it is the preferred method of evaluating endobronchial disease. However, bronchoscopy provides minimal information about areas distal to the endobronchial abnormality in patients with high grade obstruction. Clinically, virtual bronchoscopy is a non-invasive method to evaluate intra and extra luminal central airway lesions. Virtual bronchoscopy has evolved from advances in computer technology that have allowed the information from CT images to be processed into three dimensional images of the central airways. Virtual bronchoscopy has been used in pre-procedure planning, the evaluation of bronchial anastomoses and airway stenosis. As technology improved, the clinical applications of virtual bronchoscopy will continue to evolve.

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### **Transthoracic needle aspiration**

Percutaneous transthoracic needle aspiration is used most commonly to obtain tissue from patients who are suspected of having lung tumours, but it can also be used to establish the etiology of infections. Percutaneous needle aspiration is relatively good at establishing the diagnosis of lung malignancy but it is not very good at establishing specific benign diagnosis. In one series of 130 patients who had undergone TTNA, had a sensitivity of 74% for the detection of malignancy but established the diagnosis in only two of 28 patients with benign disease. TTNA is more sensitive when the lesion is larger. In patients who are suspected of having lung cancer and who are operative candidates, TTNA should be performed only if the results of the aspiration will influence whether or not surgery will be performed. If it is decided beforehand that surgery will be performed only if the aspiration is positive, TTNA should be performed. Also, if surgery will not be performed only if the TTNA is negative, then TTNA is not performed. Visualization of the lesion for guidance of the procedure may be obtained with CT scanning, ultrasonography or fluoroscopy.

TTNA is also useful in sampling mediastinal nodes in patients with lung cancer. In one recent series, studies were performed CT guided fine needle aspiration with or without core biopsy in 89 patients with mediastinal lymphadenopathy 1.5 cm in diameter. Mediastinal TTNA was diagnostic in 69 of 89 patients. They concluded that mediastinal TTNA should be performed before mediastinoscopy in the staging of lung cancer or the work up of mediastinal masses. The most common complication of TTNA is pneumothorax, which occurs in approximately 35% of patients undergoing the procedure. Indeed, TTNA is the most common cause of iatrogenic pneumothorax. Approximately 10% of the patients who develop a pneumothorax are treated with tube thoracostomy. Another complication is transient hemoptysis, occurring in about 10% of patient. Other rare complications include bacterial complications of the pleural space, allergic anesthetic reactions, vasovagal reactions, soft tissue infection, cancer seeding at the insertion site and air embolism. Contraindications to the procedure include a bleeding diathesis, bullous lung disease in the area of the biopsy, local cutaneous lesions, pulmonary hypertension or a lesion abutting the mediastinum or hilum.