INTRODUCTION
Anesthesiologists often care for patients with disorders and syndromes that are unfamiliar to us. Our patient, however, had a balanced chromosomal translocation between chromosomes 12 and 17 that had never been previously described in the literature (1). He presented for surgery for severe aortic insufficiency. This case identifies and reviews the clinical challenges associated with unfamiliar syndromes for the anesthesia provider.

CASE PRESENTATION
An eleven-year-old with a unique de novo chromosomal translocation presented for aortic valve homograft placement for severe aortic insufficiency. General endotracheal anesthesia with ASA standard monitors and arterial and central venous catheters was planned. The patient underwent a smooth mask induction and intravenous line placement. Mask ventilation was somewhat challenging secondary to his narrow face preventing proper mask seal. Additionally, his neck was quite rigid preventing the cervical flexion and atlanto-occipital extension required for alignment of pharyngeal axes and airway patency. Initial direct laryngoscopy revealed a grade IV view despite significant laryngeal manipulation. Patient repositioning and attending anesthesiologist DL also revealed a grade IV view. Laryngeal mask airway placement was then attempted but was difficult due to limited mouth opening. It was ultimately successfully intubated via asleeop fiberoptic bronchoscopy through a Berman oral airway.

His intraoperative course and surgical repair was otherwise unremarkable. Surgical exploration revealed myxomatous valvar tissue. He was admitted to the pediatric intensive care unit postoperatively where he remained hemodynamically stable and was successfully extubated postoperative day one.

DISCUSSION
Coexisting airway challenges and aortic valve pathology made this case challenging for the anesthesia provider. Our patients' airway anatomy (Fig 3) was severe enough that he required tracheostomy in the neonatal period and his twin sibling expired in infancy due to airway obstruction. We thus anticipated a difficult pediatric airway, which varies in incidence by age and ranges from 0.57% - 0.85% in the general population (2-4). Our patient's thickened and insufficient aortic valve was the indication for his surgical intervention (Fig 1-2) and he was found to have pan-valvar tissue abnormalities. Our patient's phenotypic anomalies including mandibular hypoplasia and irregularities of cartilaginous structures are likely related to his translocation of chromosomes 12 and 17, however the exact mechanism is unclear. Interestingly, osteogenesis imperfecta, a genetic disorder associated with collagen anomalies and aortic insufficiency has also been linked to chromosome 17 and a particular craniofacial phenotype.

CONCLUSION
Ironically, our patient's most perilous intervention was not cardiac surgery, but airway management. Anesthetic implications of unfamiliar clinical syndromes require thorough attention to past medical history and physical exam coupled with meticulous preparation. It is possible that phenotypic trends may be extrapolated across clinical syndromes when the underlying chromosomal abnormality has been identified. While this might aid in helping us to understand patient phenotypes, this may also present an additional layer of complexity for the pediatric anesthesiology provider as more chromosomal abnormalities are sequenced in our increasingly complex patient population.

REFERENCES
4. Ezri T., Weisenberg M., Khazin V., et al: