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A Case of Cannot Intubate, Cannot Ventilate

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Introduction

The inability to intubate or ventilate a critical patient is a very challenging, often terrifying situation for the anesthesiologist. Certain elements of the physical exam or patient history may help predict difficult situations, and alter the anesthetic plan. We present an application of the ASA Difficult Airway algorithm.

Case Report

A 69 year old male with a past medical history of parotid gland carcinoma status post resection and radiation therapy with extensive jaw, neck and facial reconstruction, G-tube placement, COPD, HTN who presented for CTR and ulnar tunnel exploration. He had a previous history requiring multiple tracheostomies with takedowns. Of note, patient had refused previous permanent tracheostomy over objections of family members. Patient had undergone similar procedure successfully under regional anesthesia.

A right axillary block was placed under 2 mg of midazolam successfully. He was maintained on a 20 mcg/kg/min Propofol drip. The patient tolerated the right CTR without issue. At the time of incision for the ulnar tunnel release procedure, the patient was noted to experience significant pain. He was given a dose of 50 mcg fentanyl.



Figure 1 A sagittal view of a recent cervical CT of the patient showing the extensive anatomical reconstruction of his oral cavity, pharynx, and airway

Around one minute later, the patient was noted to be apneic with a declining oxygen saturation. Mask ventilation was attempted without success with a subsequent unsuccessful attempt to place a #3 LMA. A code was called at that time. An emergency needle cricothyroidotomy kit was available and opened. Eventually, the patient was able to be ventilated via bag mask with improvement in oxygen saturation. An available surgeon placed a surgical tracheostomy with 6 fr cuffed cannula with immediate improvement in saturation. Patient awoke spontaneously moments later with spontaneous respirations and no visible neurological deficits. He was recovered in ICU without further complications and was discharge home on post operative day 4.

Discussion & Conclusion

This is a good example of the ASA difficult airway algorithm used successfully during a case. In retrospect, this patient should have received an awake tracheostomy prior to presentation to the OR as regional anesthesia may not be sufficient with emergent conversion to general anesthesia being necessary.