

Difficult Airway in the Parturient

Anesthetic Pearls: Anesthetic Implications and Management of Difficult Airway in the Parturient

Recognition of Difficult Airway Potential

Certain anatomic features may suggest a difficult airway such as very large breasts and heavy chest wall, large tongue, no teeth and sunken cheeks, fixed position of head and neck, massive jaw, upper airway mass. Consideration must be given into alternatives to general anesthesia if there are any doubts about maintaining airway patency during anesthetic induction.

1. Regional - all patients should receive supplemental oxygen and prophylaxis against acid aspiration in preparation for possible general anesthesia.
2. Local - Patients with difficult airway requiring urgent c-section (and contraindication to spinal or epidural anesthesia), local anesthesia may be the primary anesthetic technique.
3. Awake intubation followed by general anesthesia (care taken to not over-sedate leading to increased risk of aspiration).
 - A. Direct laryngoscopy (after adequate airway anesthetic)
 - B. Blind nasal intubation (be sure to use nasal constrictor and small tube)
 - C. Fiberoptic intubation
 - D. Retrograde intubation
 - E. Glide-scope intubation

Unrecognized Difficult Airway

- “CALL FOR HELP”
- Proceed directly to the difficult airway algorithm.
- Do **not** “burn bridges” and act in a cautious manner.

- I. Cannot intubate, can mask ventilate, no fetal distress.
 1. Maintain cricoid
 2. Try above intubation techniques
 3. Awaken patient then surgical airway, LA, regional
 4. Cease prolonged persistent intubation attempts which can lead to increased difficulty in mask ventilation, edema, increased secretions, and airway reactivity)
- II. Cannot intubate, can mask ventilate, fetal distress.
 1. First option is to awaken patient (likely save mother, but may result in fetal demise).
 2. Cricothyrotomy or tracheostomy
 3. Continue mask ventilate and maintain cricoid pressure.
 4. Consider LMA (remember no aspiration protection and possible desaturation during insertion).
- III. **Cannot intubate, cannot mask ventilate.**
 1. Wake patient
 2. Deliberate intubation and tamponade of esophagus.
 3. LMA (fastrack LMA and then use fiberoptic)
 4. Transtracheal jet ventilation (TTJV)
 5. Emergent surgical airway
 6. Combitube
 7. Glide-scope
- IV. Extubation of patient with difficult airway.
 - Remember - reintubation is likely to be more difficult than original intubation
 - Ideally: Controlled, gradual, reversible withdrawal of ETT (adequate suctioning and insure optimized oxygenation)
 - Consider airway exchange catheter or jet stylet for extubation.

Difficult Airway Algorithm

