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# Management of “Cannot Intubate/Cannot Mask Ventilate” Scenario during Rapid Sequence Induction

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## Introduction

Airway management is a real challenge during rapid induction of a morbidly obese patient with acute abdomen, full stomach, and history of difficult mask ventilation and intubation. After failing to intubate with glidescope, we successfully managed the airway with Air Q intubating Laryngeal Mask Airway (LMA) under fiberoptic guidance.

## Case Description

A 48-year-old morbidly obese male with a recent laparoscopic colon resection presented for laparotomy with distended abdomen and acute abdominal pain due to an anastomotic leak. The prior airway management note indicated difficulty with both mask ventilation and elective intubation with rigid video laryngoscopy using glidescope. During rapid sequence induction we were unable to intubate with glidescope and oxygen saturation was decreasing. A standard LMA was placed and patient was ventilated successfully. Subsequently, his airway was managed with a 7.5 size endotracheal tube through an AIR Q intubating LMA under fiberoptic guidance. Cricoid pressure was maintained throughout and ventilation was limited to low peak airway pressure in order to prevent aspiration in this acute situation.

## Assessment

1. Look for signs of difficult airway
2. Mallampati 3 and 4 grades
3. Look for prior intubation record
4. Look for mask ventilation history during prior anesthesia

## Signs of Difficult Airway

- ✓ Limited neck movement
- ✓ Large tongue
- ✓ Prominent incisors
- ✓ Large neck circumference
- ✓ Facial features → difficult mask fit
- ✓ Receding jaw
- ✓ Decreased thyromental distance
- ✓ Presence of neck mass
- ✓ Prior radiation therapy to neck

## Management

1. Awake fiberoptic technique
2. Rigid Video Laryngoscope
3. Flexible fiberoptic intubation

## Our Management

Our patient had a history of difficult mask ventilation with prior laparoscopic colon resection. His airway was secured several days prior with a difficult glidescope intubation. He presented with acute distended abdomen due to an anastomotic leak. The nasogastric tube was suctioned. We decided on a rapid sequence intubation with glidescope intubation, which was unsuccessful. We subsequently easily intubated with AIR Q intubating LMA under fiberoptic guidance.

### Management of unanticipated “cannot intubate” scenario when mask ventilation is adequate and direct laryngoscopy fails<sup>1</sup>

1. Video laryngoscopy
2. Fiberoptic intubation
3. Intubation through intubating LMA

### Management of unanticipated “cannot intubate/cannot mask ventilate” scenario with direct laryngoscopy

1. Insert laryngeal mask airway
2. If ventilation is adequate, remove LMA after adequate oxygenation and perform rigid or flexible fiberoptic intubation
3. If ventilation is inadequate, awaken the patient
4. Otherwise, proceed with needle cricothyrotomy
5. Proceed with surgical airway

## CONCLUSION

*Based on our unique experience of “Cannot intubate/Cannot Mask Ventilate” during rapid sequence induction of a patient with acute abdomen and high risk of aspiration, we advocate intubation with AIR Q LMA, which provides a conduit for the passage of fiberoptic bronchoscope and increases the success of fiberoptic intubation.<sup>2</sup>*

REFERENCES: 1. Updated by the Committee on Standards and Practice Parameters; Jeffrey L. Apfelbaum, MD; Carin A. Hagberg, MD; Robert A. Caplan, MD; Casey D. Blitt, MD; et al : Practice Guidelines for Management of the Difficult Airway: An Updated Report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway. Anesthesiology 02 2013; 118, 251-70. 2. Eun Jin Ahn, Geun Joo Choi, Hyun Kang, Chong Wha Baek, Yong Hun Jung, Young Cheol Woo Si Ra Bang : Comparative Efficacy of the Air-Q Intubating Laryngeal Airway during General Anesthesia in Pediatric Patients: A Systematic Review and Meta-Analysis. Biomed Res Int. 2016; 6406391.