

Management of the Traumatic Airway Obstructed by Foreign Body

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Head and neck trauma patients can present significant airway challenges requiring specialized techniques and rapid decision-making.¹ This image shows a patient with a large metal foreign body impaled through her right submandibular space, hard and soft palate. She could not turn her head due to pain, and access to her neck was restricted. She was bleeding profusely from her nares and oral cavity, and was unable to control her secretions or tolerate lying back without coughing and desaturation. How should the anesthesiologist best manage this patient?

Oral intubation would have been impossible, and though emergency cricothyroidotomy or tracheostomy is often ideal in head and neck trauma,² it was likely to be extremely difficult. Along with traditional concerns including aspiration, unique airway considerations included need for expeditious action due to bleeding and desaturation, potential intracranial injury with desire to avoid increasing

intracranial pressure, potential cervical spine injury, and ability of the patient to cooperate.

Advantages of an awake nasal fiberoptic approach include the ability to avoid irreversible decisions and maintain spontaneous ventilation; disadvantages include a more prolonged process, difficulty of fiberoptic visualization with bleeding, the patient's tolerance, and hemodynamic instability. Fiberoptic intubation with airway topicalization and cautious sedation was challenging but successful. Potentially feasible alternatives included attempt at surgical airway in the sitting position, with technical difficulty accessing the neck due to positioning and patient cooperation being drawbacks. Although the American Society of Anesthesiologists' difficult airway algorithm suggests cannulation for venous extracorporeal oxygenation,³ the complexity in execution makes it unattractive in emergent situations.

Competing Interests

The authors declare no competing interests.

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