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Fiberoptic guided intubation in a trauma and c-spine injured patient
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Cervical spine injuries occur in 1,5-3% of all major trauma, those involved in head-first falls have an incidence of 10% of C-spine injury.

A patient with CGS of 7, and Sat O₂ is 95% (plus 6 Lpm of face mask O₂) it must be intubated in semi-elective manner.

The airway management of this patients requires much attention

- The potential for cervical spine injury makes airway management more complex in the trauma patient. A cervical spine injury should be suspected in all injury mechanisms involving blunt trauma.
- Patients with injury above the clavicles are at increased risk, and this is increased 4-fold if there is a clinically significant head injury (GCS < 9). Cervical spine injury is often occult, and secondary injury to the spinal cord must be avoided.
- Immobilization of the cervical spine must be instituted until a complete clinical and radiological evaluation has excluded injury.

First steps in Emergency Room:

1. Immobilize cervical spine
2. Immediate relief of airway obstruction (chin lift and oral airway all cause C-spine movement, and look for teeth, blood, etc, oral airway only cause minimal movement)
3. Oxygen by facemask (+ Guedel first and later change for Williams airway)

Ask for Difficult Airway Chart:

1. Prepare for FOB intubation, *while...Assess...*
2. Adequacy of ventilation + Hemodynamics stability and level of consciousness: Poor ventilation + # lower limb = ?BP + CGS
3. We consider possibility of basal skull# or C-spine ...decide oral airway

For a responsive + hipotensive patient: In-line manual stabilization

1. Preoxygenation 2 minutes with face mask and FiO₂ = 1
2. Cricoid pressure (in cadaveric studies may worsen a C-spine injury, but no case report indicate danger to living trauma victims), then is controversial
3. Drugs: Tiopental 2 mg/Kg or Midazolam 0,2 mg/kg iv
4. Neuromuscular Blocking Agents for intubation : succinilcholine 1,5 mg/kg after 5 mgs of non depolarizing agent and later NDBA, or Rocuronium
5. Advance a 5 mm FOB, with a 7,5 mm ET previously inserted via an oral airway, helped by a well lubricated tube.

References

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