Cannot Intubate, Cannot Ventilate!... In a Neonate.
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Introduction
• Cannot intubate, cannot ventilate is one of the most feared situations for anesthesiologist
• Much time and energy has been devoted to the development of difficult airway algorithms, but these are for adult airways
• Few descriptions and cases of difficult airways in the neonate population exist in the literature
• Our case is uniquely difficult as this neonate was previously easy to ventilate and intubate
• The outcome was an emergent tracheostomy placed over a rigid bronchoscopy, which was maintaining the airway

Case Presentation
• 3 week old male, PCA 37 weeks with a history of large VSD, hydrocephalus, and right- sided microtia taken to the OR for a g-tube placement.
• He had previously undergone GA with an easy endotracheal intubation
• Inspiratory stridor was noted just prior to induction
• IV induction, with muscle relaxant, was followed by inability to intubate
• A “white mass” was blocking the view of the glottic opening during subsequent DL’s
• Mask ventilation became increasingly difficult and eventually, impossible
• An ENT surgeon was called and passed a rigid bronchoscope into the trachea, past the mass, without identification of the glottic opening.

Learning Points
• Unanticipated difficult airway in the neonate is especially challenging, given the limited reserve
• Stridor should always be taken seriously, and evaluated prior to airway manipulation, especially in elective surgery
• LMA’s are rarely used in neonates, but should be considered in an emergency situation as a temporizing method
  • In retrospect, an LMA may have rescued the airway in this case!
• A previously easy airway doesn’t equal an easy intubation!
• Caution should be used when giving muscle relaxant in neonates, taking away SV

References