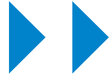
ASP

Aspiration - Gastric

longlives
ANESTHESIA PATHWAYS

Inhalation of gastric material into the airway below the level of the true vocal cords, bronchospasm, wheezing, hypoxemia, tachycardia



Start

1. **Call for "ANESTHESIOLOGIST STAT" and DIFFICULT AIRWAY CART/GLIDESCOPE**
2. **Suction airway**
   - Clear airway of particulate matter with McGill forceps
   - Remove LMA if present and suction oropharynx
   - Delegate someone to setup Fiberoptic Bronchoscope with suction
3. **If actively vomiting - Place patient on their side or turn patient's head**
4. **If passive regurgitation – Apply and maintain cricoid pressure**
5. **Stop surgery AND change position of patient into "Head-Down"**
6. **Perform Rapid Sequence Intubation**
   - Apply Cricoid Pressure; Intubate
   - Prior to ventilation (if not significantly hypoxic) – Immediately suction via ETT with flexible suction catheter
7. **Perform fiberoptic bronchoscopy of tracheobronchial tree**
   - DO NOT lavage airways with saline Suction foreign material/particulate matter
8. **Administer bronchodilators for bronchospasm or wheezing**
   - If Bronchospasm develops: Go to » CHKLST BRO
9. **Consider Lung Protective Strategy**
   - TV: 5-6 mL/kg
   - PEEP: 5-10 cm H_2O
   - FiO_2: minimize to keep $SaO_2 \geq 90\%$
   - Plateau Pressure < 30 cm H_2O
10. **Obtain Chest X-ray in the PACU or ICU**
11. **Consider ICU Admission, Arterial Line Placement, ABGs**

DRUG DOSES and treatments

Bronchospasm Treatment

Albuterol	8-10 puffs MDI or 2.5 mg nebulized via ETT/Inspiratory Limb
Ipatropium Bromide	0.5 mg via nebulizer
Magnesium Sulfate	2 g IV over 20 minutes

Equipment Instructions

Fiberoptic Bronchoscope - Assemble ASAP once Difficult Airway Cart is in the room. Attach suction and ensure light is functional

Other References

1. Avoid empirical antibiotics until a clear dx of pneumonia is made
2. Patients may not develop full blown aspiration pneumonitis and may be electively extubated at the end of the case if there is no hypoxemia present. The surgery may continue despite aspiration if the anesthesiologist and surgeon agree the patient is stable.
3. Steroids should **NOT** be routinely administered to patients

PROVIDENCE
ANESTHESIOLOGY ASSOCIATES