BRO Bronchospasm

longlives ANESTHESIA PATHWAYS

Wheezing, airway obstruction, hypoxia, difficult ventilation

Start

1. **Call for "ANESTHESIOLOGIST STAT"**
2. **Increase FiO_2 to 100%**
   - If intubated: Manual bag ventilation
     - Evaluate pulmonary compliance (look for shark fin $ETCO_2$ waveform)
     - Identify all causes of high-circuit pressure
   - Consider need for intubation if clinically indicated
3. **If cardiovascular instability and/or cutaneous signs**
   - Consider anaphylaxis: Go to » CHKLST ANA
4. **Evaluate depth of anesthesia**
   - Consider increasing VOLATILE ANESTHETIC
     - Sevoflurane or Isoflurane preferred, AVOID Desflurane
   - Consider PROPOFOL bolus 0.5-1 mg/kg, or ketamine bolus 10-20 mg, gtt 1-3mg/kg/hr
5. **Administer inhaled bronchodilators**
   - ALBUTEROL via nebulizer or metered-dose inhaler
6. **Administer GLUCOCORTICOID - Methylprednisolone IV**

7. **If significant hypotension...**
   - Disconnect anesthesia circuit to rule-out Auto-peep
   - Consider Anaphylaxis: Go to » CHKLST ANA
8. **Consider...**
   - Chest X-Ray
   - Medications noted in pink box

Critical Changes

If PEA develops: Go to » CHKLST CAA

If ANAPHYLAXIS: Go to » CHKLST ANA

DRUG DOSES and treatments

Albuterol	8-10 puffs MDI or 2.5 mg nebulized via ETT/Inspiratory Limb
Methylprednisolone	1mg/kg IV – or –
Hydrocortisone	200mg IV
Ipatropium Bromide	0.5mg via nebulizer
Magnesium Sulfate	2g IV over 20 min
EPInephrine	10-20 mcg IV or 2-10mcg/min IV
Lidocaine	1-2mg/kg IV or ETT
Ketamine	0.5-1mg/kg IV

Differential Diagnosis

Anaphylaxis	**Kinked or Obstructed Tube/Circuit**
Inadequate Anesthesia	**Mucous Plugging of Airway**
Esophageal Intubation	**Pulmonary Aspiration**
Pulmonary Edema	**Pneumothorax**
Unilateral Wheezing:	Endobronchial Intubation or Foreign Body Obstruction

CPR and Resuscitation

Airway	Assess and secure, confirm endotracheal intubation
Circulation	If hypotension, rule out auto-peep

PROVIDENCE ANESTHESIOLOGY ASSOCIATES