INHALED FOREIGN BODY IN CHILDREN:

GUIDE TO ANAESTHESIA

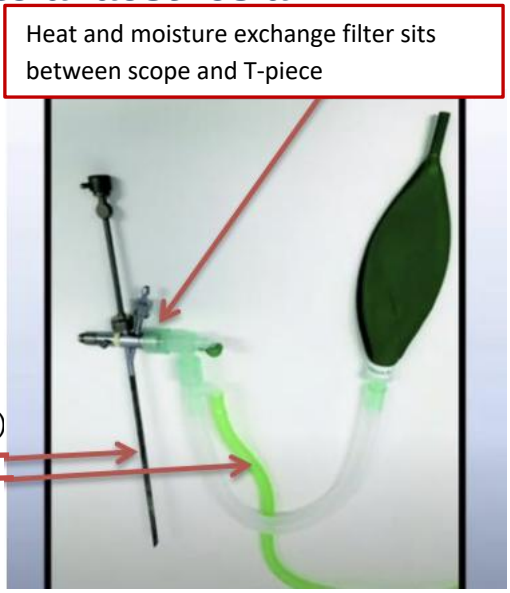
TARGET AUDIENCE	Anaesthesia and critical care
PATIENT GROUP	All paediatric patients at Wishaw hospital requiring airway management for an inhaled foreign body.

Clinical Guidelines Summary

This guideline is revised from and supersedes ‘Paediatric Airway Emergencies and ENT Emergencies in Children’ Guide for Wishaw anaesthetic department 2017, reviewed 2020. The guide has been disseminated within the anaesthetic department for consensus approval prior to publication.

It provides a guide to management of paediatric patients with inhaled foreign body at Wishaw hospital.

Inhaled foreign body in children: guide to anaesthesia



FASTING
- Ideally fasted
- Depends on clinical state/urgency

PREMEDICATION
- Keep child calm to prevent dislodging foreign body
- Avoid premedication if possible (increased risk of apnoea)
- If necessary: 0.5mg/kg midazolam orally

SPECIFIC EQUIPMENT
- Two anaesthetists
- Cut uncuffed endotracheal tubes (size appropriate to patient)
- Paediatric Storz Bronchoscope
- Ayre's T-piece
- Sevoflurane vaporiser on anaesthetic machine
- Mucosal atomisation device for local anaesthetic to cords

DRUGS
- Otrivine
- Lidocaine 4mg/kg
- Emergency drugs: suxamethonium 2mg/kg and atropine 20mcg/kg – both with 22G hypodermic needle attached for intramuscular use if required
- Anticholinergic (eg glycopyrrolate 4mcg/kg) to reduce bradycardia, secretions and bronchoconstriction
- Dexamethasone 0.3mg/kg intravenous after induction

ANAESTHESIA PLAN

INDUCTION
- Avoid distress – keep parent present
- Pre O_2 (avoid N_2O – gas trapping), facemask with 100% O_2
- Gradual increase in sevoflurane – start 0.5%, double every 3-4 breaths
- Deep anaesthesia (eye signs, respiratory pattern and abdomen)
- Parent should be escorted out
- Intravenous access by second anaesthetist
- Otrivine, one application per nostril, then return to face mask ventilation
- Laryngoscopy and verbalise view to room
- 4mg/kg lidocaine to cords via mucosal atomiser device (half above cords, half below cords)
- Nasal intubation with cut tube, tip visible just below soft palate (acts as nasal airway)
- Secure tube with Elastoplast tape, covering both nostrils
- Close mouth and other nostril
- Attach T-piece to nasal tube – spontaneous ventilation with jaw thrust

MAINTENANCE – spontaneous breathing with volatile
- Ayre's T-piece on side arm of bronchoscope (connector)
- High concentration sevoflurane and 100% O_2 throughout
- Vigilance with saturations and depth of anaesthesia – tell surgeon if they need to pause and remove scope
- Surgeon can oxygenate: T-piece on nasal tube, with mouth closed and jaw thrust

POST-OP
- Remain fasted until local anaesthetic worn off (2 hours post lidocaine spray)
- Fluids/glucose if required

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Appendices

1. Governance information for Guidance document

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CONSULTATION AND DISTRIBUTION RECORD	
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