**Título:** MANAGING AND SECURING THE BLEEDING UPPER AIRWAY IN A PATIENT SUSPECTED TO HAVE SARS-COV-2 INFECTION

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Resumo:

Introduction

Tracheal intubation, being an aerosol-generating procedure, represents a potentially high-risk infectious in a patient suspected to have SARS-CoV-2 infection. Current recommendation, when tracheal intubation is needed, is to give primacy to videolaryngoscopy (VLa), but this could be a particularly challenging approach on a bleeding airway.

Clinical case

A 67-year-old male patient, with hypertension, epilepsy, cerebral spontaneous hemorrhage with spastic left hemiparesis and dysphagia, an acute myocardial infarction and an eluting coronary stent, was admitted to the emergency with a profuse hematemesis associated with hypotension and an upper digestive endoscopy was performed, without evidence of injury from the oropharynx to the stomach. Patient was conscious, hypoxemic (PaO2/FiO2 of 160, breathing with aFiO2 of 50%), hypotensive (PAS/PAD of 95/46 mmHg) with little response to fluid therapy, with signs of hypoperfusion. The arterial blood gas analysis showed acidosis (pH 7.22), with with a lactate of 8.17 mmol/L and 7.2g/dL of hemoglobin. Two units of packed unmatched red blood cells were transfused and the patient was transferred to the operating room (OR) for emergent otolaryngology surgery. Without time to do the screening test for SARS-CoV-2, the patient was considered a suspected SARS-CoV-2 case. A strategy of first approach by VLa was planned, with a frova intubating introducer available, followed by a plan of attempt of direct laryngoscopy and, as a last resort, emergency cricothyroidotomy or surgical tracheostomy, with previous ultrasound marking of anatomic structures. Only the most experienced anesthesiologist and the anesthesiology nurse were in the OR with the rest of the anesthesiology-surgical team prepared for immediate access to the operating room, including a 2nd anesthetist equipped and ready to act if necessary. The patient was successfully intubated on the first approach, and the hemorrhage was stopped with nasal, oral and hypopharyngeal tamponade, showing an epistaxis, without individualizing the bleeding point. The patient was transferred to the ICU intubated, under sedation and vasopressor support. After 24h in the ICU, the patient’s clinical picture stabilized, without recurrence of objective hematic losses, in addition to residual blood gastric drainage. He showed partial recovery from organ dysfunction, with a marked improvement in hyperlacticaemia by the time of transfer (2.5 mmol/L of lactate) and the result of the COVID-19 screening test was negative.

Discussion

This was a case of successful approaching and securing a bleeding upper airway, particularly demanding due to the infectious high-risk of airway approach in patient suspected to have SARS-CoV-2 infection, and in which the planning proved to be an excellent and necessary weapon of the anesthetic-surgical team to guarantee the safety of the team and of the patient.