STATUS ASTHMATICUS

MODULE: CRITICAL INCIDENTS

TARGET: ANAESTHETIC & ACCS TRAINEES

BACKGROUND:

Management of bronchospasm is a core skill common to the acute medical specialties. Management should include consideration of differential diagnoses and treatment should follow established British Thoracic Society guidelines. If airway protection is required then an anaesthetic technique which avoids further exacerbation of bronchospasm should be adopted, and appropriate ventilatory settings applied.

RELEVANT AREAS OF THE ANAESTHETIC CURRICULUM

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3.1 Manages the care of the critically ill patient with specific acute medical conditions
INFORMATION FOR FACULTY

LEARNING OBJECTIVES:

- Differential diagnosis of the patient with bronchospasm
- Assessing severity of asthma attack
- Management of status asthmaticus, including difficulties around invasive ventilation

SCENE INFORMATION:

- Location: Recovery

EQUIPMENT & CONSUMABLES

- Manikin – on theatre trolley.
- Oxygen mask
- Nebuliser mask
- Checked, disconnected anaesthetic machine
- Stocked Airway trolley
  - Laryngoscopes (2 x Macintosh)
  - ET Tubes (Various Sizes)
  - OP, NP and Advanced Supraglottic airways (iGels, LMAs)
- Water’s Circuit

- Anaesthetic Junior Trainee
- Recovery Nurse
- Anaesthetic Senior Trainee

‘VOICE OF MANIKIN’ BRIEFING:

You have mild to moderate asthma usually, but are currently suffering a life-threatening asthma attack in recovery following a day case orthopaedic procedure.

You are reathless, wheezy, coughing and unable to speak in more than one or two word sentences. You deteriorates during the scenario to silent chest

Asthma usually well controlled with Clenil and Salbutamol inhalers. Animal hair and hay fever are triggers.
You do not know usual Peak Flow measurements.
Last had oral steroids (Predinisolone) 2 years ago with a chest infection.
Never had nebulisers. No asthma related hospital admissions. Never been ventilated.
No other medications. No known drug allergies.

‘RECOVERY NURSE’ BRIEFING:

You have been looking after this patient for about 15mins. The LMA came out 10mins ago. Over the last 5 mins the patient has been complaining of chest tightness, and coughing a lot. They sound wheezy.

You know they are asthmatic from the anaesthetic chart, but have not got any asthma medications prescribed. You have called the doctor to review the patient.

You are able to administer nebulisers. If asked you have no anaesthetic skills beyond basic airway manoeuvres, holding a face mask or bag ventilation (2 person technique). You cannot connect up the anaesthetic machine.
CONDUCT OF SCENARIO

INITIAL SETTINGS
A: Own.
B: SaO2 96% on nasal O2. RR 28/min. Wheeze.
C: 165/85, HR 95
E: Sitting upright.
Few minutes for history taking, but progressive worsening of breathlessness and wheeze.

EXPECTED ACTIONS
• ABCDE assessment.
• Monitoring.
• Consider differential diagnoses
• High flow O2 and/or administration of salbutamol 2.5-5mg neb +/- ipratropium 500mcg neb
• Ensure IV access. Take blood for labs, cultures, glucose.
• Commence treatment with steroids, give iv magnesium 2g.
• Consider CXR.
• ABG: pH 7.36, pCO2 5, pO2 12, BE -2, lac 1.6
• Call for help
• Consider other therapy e.g. aminophylline

WORSENING ASTHMA
A: Own.
B: SaO2 92% unless O2 increased or neb given.
RR 36/min, Wheeze.
C: BP 165/85. HR 125
Increasing difficulty talking. Weak cough.

NO RESPONSE TO TREATMENT
A: Own.
B: SaO2 94% despite O2 or neb. RR 48/min.
Silent chest. Increased resistance. Decreased compliance.
C: BP 120/80. HR 150
D: Eyes half open. Unable to talk

REDUCED DIFFICULTY
Help arrives early
Back to back neb therapy start to ease bronchospasm provided appropriate therapy given.

EXPECTED ACTIONS
• Call for help/help arrives
• Rpt ABG pH 7.30, pCO2 7, pO2 9, BE -3, lac 2.6
• Decision to intubate and ventilate

EXPECTED DIFFICULTY
• Consider ketamine induction
• Avoidance of histaminergic drugs (e.g. atracurium, morphine)
• Volatile (Iso/Sevo) maintenance
• Mechanical ventilation easy

INCREASED DIFFICULTY
• Post induction: Mechanical ventilation difficult. High resistance, poor compliance.
• Appropriate ventilation settings necessary to prevent desaturation and hypercapnoea.

RESOLUTION
Bronchospasm managed, or at faculty discretion.
Further plan e.g ward observation or ICU admission as appropriate.

INCREASED DIFFICULTY
If participants performing well, consider further complication such as tension pneumothorax.
DEBRIEFING

POINTS FOR FURTHER DISCUSSION:

- Differential diagnosis of the patient with bronchospasm
- Assessing severity of asthma attack
- Management of status asthmaticus, including difficulties around invasive ventilation

DEBRIEFING RESOURCES

British Thoracic Society/SIGN Asthma Guideline 2011
Quick Reference Guide page 13-14 has the protocol for assessment and management of asthma exacerbations.
Chapter 6 of the full guideline: Management of acute asthma has evidence based descriptions of each step in the management of an asthma exacerbation.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414026/
INFORMATION FOR PARTICIPANTS

KEY POINTS:
- Differential diagnosis of the patient with bronchospasm
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Version 9 – May 2015  
Editor: Dr Andrew Darby Smith  
Original Author: Dr P Shanmuha
PARTICIPANT REFLECTION:

What have you learnt from this experience? (Please try to list 3 things)

How will your practice now change?

What other actions will you now take to meet any identified learning needs?
PARTICIPANT FEEDBACK

Date of training session:..............................................................................................................................................

Profession and grade:......................................................................................................................................................

What role(s) did you play in the scenario? (Please tick)

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<th>Ticked</th>
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<td>Primary/Initial Participant</td>
<td></td>
</tr>
<tr>
<td>Secondary Participant (e.g. ‘Call for Help’ responder)</td>
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<tr>
<td>Other health care professional (e.g. nurse/ODP)</td>
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<tr>
<td>Other role (please specify):</td>
<td></td>
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<td>Observer</td>
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<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<td>I found this scenario useful</td>
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<td>I understand more about the scenario subject</td>
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<td>I have more confidence to deal with this scenario</td>
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Please write down one thing you have learned today, and that you will use in your clinical practice.

How could this scenario be improved for future participants?  
(This is especially important if you have ticked anything in the disagree/strongly disagree box)
FACULTY DEBRIEF – TO BE COMPLETED BY FACULTY TEAM

What went particularly well during this scenario?

What did not go well, or as well as planned?

Why didn’t it go well?

How could the scenario be improved for future participants?