

Awake Nasal Fiberoptic Intubation Following Failed Spinal Anesthesia in Severe Ankylosing Spondylitis A Case Report

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INTRO

Severe ankylosing spondylitis (AS) can render neuraxial anesthesia impossible and conventional airway management techniques unacceptably high risk.

CASE PRESENTATION

78-year-old man with advanced AS, predicted difficult airway and two previous traumatic experiences with awake fiberoptic intubation presented for sacral wound I&D. After discussion, patient agreed to a primary plan for SAB and secondary plan for an awake nasal FOI.

In the OR, anticipatory glycopyrrolate administered. Ultimately, attempts by experienced anesthesiologist for spinal anesthesia failed.

Patient repositioned and transitioned early to a structured awake nasal fiberoptic intubation with targeted airway topicalization and minimal sedation.

DISCUSSION

- Severe AS resulted in obliterated spinal anatomy & prevented neuraxial access
- Antisialagogue given early, allowing for improved effect and longer duration of mucosal lidocaine topicalization
- Spontaneous ventilation maintained & minimal sedation utilized
- Intubation with Shiley™ reinforced oral-nasal endotracheal tube successful, atraumatic, and very well tolerated
- No complications or local anesthetic toxicity

CONCLUSION.

In advanced AS, awake fiberoptic intubation should be considered part of a planned strategy — not a rescue technique — when neuraxial anesthesia fails.

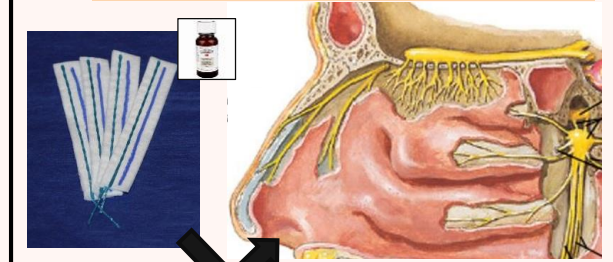
In severe ankylosing spondylitis, a preplanned and targeted awake nasal fiberoptic intubation is the key backup strategy in the setting of failed neuraxial techniques.



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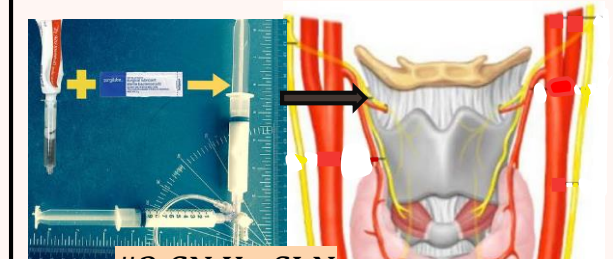
Targeted topicalization for aFOI



#1 CN V2



#2 CN IX



#3 CN X - SLN



#4 CN X - RLN