

# Cesarean Section in a Parturient with Profound Tracheal Stenosis and Placenta Increta

Joel Sirianni MD, Katherine Herbert MD, David A. Gutman MD, Mike Marotta MD

## Case Description

- 33-year-old G5P3013 at 35 weeks' gestation presented to the anesthesia preop clinic with a suspected placenta accreta

## Patient Background

- **PMH**
  - BMI 37, Anemia, GERD, Childhood asthma
  - Cesarean section x3
  - MVA in 2004 with report of traumatic intubation & temporary tracheostomy with residual tracheal stenosis

### Airway History

2004

Traumatic intubation after MVA

2013

30% subglottic stenosis

2016

- Failed intubation x2 by anesthesia with 5.5 ETT
- Successful intubation by ENT with rigid bronchoscopy & 5.0 ETT

2021

50% glottic stenosis & subglottic stenosis noted on flexible laryngoscopy

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**Anesthetic Plan : general anesthesia with ENT to secure airway with direct laryngoscopy**  
**Back up plans: Emergent balloon dilation of subglottic space or Emergent tracheostomy**

RSI performed

First intubation attempt  
unsuccessful by  
ENT resident  
  
Second attempt  
successful by ENT  
attending

Ureteral stents  
placement, REBOA  
placement

Delivery of baby &  
confirmation of  
placenta increta

Hysterectomy  
proceeded  
  
EBL was 5L  
requiring multiple  
transfusions

Extubated  
uneventfully after  
6 hours of  
intubation

## **ENT Intubation notes:**

- **cartilaginous deformity of anterior right lateral trachea**
- **couple millimeters of space around 6.9 mm outer diameter of tube in anterior trachea**
- **Grade 1 view, passed 5.0 MLT**

## **End of Case notes:**

- **hemodynamically stable**
- **spontaneously breathing with > 6mL/kg tidal volumes**
- **following commands**
- **a positive cuff leak**

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## Postoperative course:

- Remained uneventful without the development of stridor, dyspnea, or hypoxia
- Discharged home with a steroid taper

## Discussion:

- Patient with a placenta increta and known difficult airway due to tracheal stenosis requires careful consideration by the multidisciplinary team
- With the risks of aspiration and failed intubation already higher in this patient population, contingency plans should be established and well-discussed prior to induction.