

Background

- Ex utero intrapartum treatment (EXIT) is a specialized mode of delivery in which fetoplacental circulation is maintained to allow for critical interventions prior to fetal delivery
- Can be indicated for conditions that pose high risk of fetal cardiopulmonary compromise including:
 - Head and neck masses
 - Mandibular anomalies
 - Pulmonary malformations
 - Mediastinal masses
- Given case complexity, meticulous planning and interdisciplinary collaboration are essential.¹



An Early EXIT

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22w

Patient was 19 yo G1P0 with history of asthma, depression, and obesity whose pregnancy was complicated by an incidentally found fetal oropharyngeal mass

27-33w

Referred to UNC MFM where she underwent further testing showing a 6-cm oropharyngeal mass causing oral cavity obstruction and polyhydramnios
After extensive counseling, plan for EXIT at 34w0d

33w3d

Presented with PPROM requiring rapid coordination of multidisciplinary team
Patient underwent neuraxial and general anesthesia for EXIT

- Pre-op: epidural, T&C, aspiration prophylaxis
- Intra-op: RSI and videoblade, arterial line and 2 large bore IVs, maintenance with sevoflurane and remifentanyl before transitioning to TIVA after delivery, phenylephrine gtt and boluses when needed
- Post-op: epidural for pain control through POD1

After failed attempts at nasal fiberoptic intubation, fetus was orally intubated, delivered, and transferred to NICU



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Learning Points

- Although EXIT procedures are ideally scheduled, the fetal anomalies that necessitate EXIT may increase risk of preterm delivery
- Thus, early multidisciplinary planning is essential in case of urgent delivery
- Because of thorough preparation, contingency planning, and effective communication, the team adapted rapidly and safely performed the EXIT

