Management of Regurgitation and Suspected Aspiration.

TARGET AUDIENCE	Secondary Care: Obstetricians, Anaesthetists, Midwives, Nurses.
PATIENT GROUP	Obstetric Patients.

Clinical Guidelines Summary

Immediate Management of regurgitation and suspected aspiration in Obstetric Theatre:

- Place the patient in a head down position with left lateral tilt.
- Suction any material from the oropharynx.
- Administer 15litres/minute of oxygen via trauma mask.
- Page 2222 and declare an Obstetric Emergency. Get the resuscitation trolley.
- Intensive Care Team to be notified.

The patient should be intubated if adequate oxygenation cannot be maintained, the patient is unable to protect their own airway or further tracheobronchial suction is required remembering to suck out any tracheal residue before manual ventilation is instituted.

If aspiration occurs in the operating theatre the operative procedure should be continued only if it is essential for the safety of the mother or the infant. The mother's health takes priority over the infant in extreme situations.

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Pulmonary aspiration can result in intrapulmonary process consistent with acute lung injury and ARDS [1]. These patients may be best cared for in HDU/ACCU depending on the severity of their condition, as a minimum they should be managed in the maternity HDU. If transfer to ACCU is required, this should be arranged with the on call ACCU consultant.

Initial symptoms are caused by chemical pneumonitis and not infection. There is no proven benefit for the routine use of prophylactic antibiotics, nor corticosteroids. [1] Antibiotics are reserved for use if secondary respiratory infection develops. [3]

Symptomatic patients will need further investigations including chest X-ray and arterial blood gases and advanced management such as oxygen therapy or ventilator support.

Further management include regular Bronchodilators by nebulizer (Salbutamol 5mg +/- Ipratropium 500mcg) and regular physiotherapy.

Circulatory shifts can lead to pulmonary oedema. Urinary catheterization should be performed and hourly urine output measurement commenced. Central Venous Pressure monitoring can be beneficial in guiding fluid management.

An Incident FormDatix should be completed once the situation allows.

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References/Evidence

1. Chestnut's Obstetric Anaesthesia 2009, chapter 29, page 633-649.

2. Anaesthesia & Intensive Care Medicine 2001; "Regurgitation, Vomiting and Aspiration" **2:9** p 361 Davies P, Warwick J

3. Anaesthesiology 1993; **78**: 56 – 62 "Clinical significance of Pulmonary aspiration during the perioperative period" Warner M A, Warner M E, Weber J G.

Appendices

1. Governance information for Guidance document

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Endorsing Body:	Maternity Clinical Effectiveness Group. Maternity Anaesthetic Team.
Version Number:	5
Approval date	**December 2024**
Review Date:	December 2027
Responsible Person (if different from lead author)	M. Dalidowski.

CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	Khaled Razouk, Hamish McKay
Consultation Process / Stakeholders:	Anaesthetic Department Wishaw Hospital; Maternity Department; Theatres.
Distribution	Theatres, Maternity, Anaesthetists, Intensive Care.

CHANGE RECORD			
Date	**Lead Author**	**Change**	**Version No.**
March 2007	**Dr J Collie**	*Original*	1
June 2011	Dr G Peters	Update	2
March 2016	Dr K Razouk	Update	3
November 2020	Dr H Mckay	Update	4
December 2024	Dr M Dalidowski	Update	5

2.You can include additional appendices with complimentary information that doesn't fit into the main text of your guideline, but is crucial and supports its understanding.

e.g. supporting documents for implementation of guideline, patient information, specific monitoring requirements for secondary and primary care clinicians, dosing regimen/considerations according to weight and/or creatinine clearance