

ANAESTHESIA/SEDATION FOR ENDOSCOPY

Beware Unexpected Aspiration

The Council has noted the frequency of cases of unexpected aspiration during anaesthesia/sedation for upper and lower gastrointestinal endoscopy. The Council is most concerned by evidence of emergency endoscopic procedures being performed with an unprotected airway.

In a number of cases there has been failure to follow the basic principles of airway management when anaesthetic agents have been employed in patients with known gastric contents, resulting in death or major morbidity. Where protective reflexes are lost, the term 'sedation' is a misnomer and the usual standards of safe practice should not be relaxed.

Special attention should be paid to patients undergoing a prolonged gastroscopy, colonoscopy or ERCP and particularly where there is active bleeding. These cases may present a number of challenges to the anaesthetist, including working in an unfamiliar environment (for example, Radiology), poor assistance, abnormal positioning (especially ERCP) and frail elderly patients with multiple co-morbidities.

While endotracheal intubation is usually not necessary in uncomplicated gastroscopy/colonoscopy, the anaesthetist should always ascertain whether there may be gastric dilatation and also recognise that suction through an endoscope may not always be effective. A number of cases reported regurgitation and aspiration immediately after removal of the endoscope. There should also be recognition that the amount of air injected into the stomach during gastroscopy or into the bowel during colonoscopy can be very large.

There also appears to be poor appreciation of the hazards associated with oesophageal pathology, such as tumours, achalasia and strictures or obstruction of the gastric outlet, all of which may increase the risk of aspiration. Additional manoeuvres such as rolling the patient to the supine position or manual compression of the abdomen to facilitate passage of the endoscope up the bowel will also increase the likelihood of aspiration.

The Council believes that standard protection of the airway with a rapid sequence induction and endotracheal tube is the safest option for emergency procedures involving endoscopy and that appropriate monitoring¹ should be employed, including the use of end-tidal CO₂. Serious consideration should also be given to endotracheal intubation in elective patients with known significant gastro-oesophageal reflux.

1. Australian and New Zealand College of Anaesthetists (ANZCA) PS 18, *Recommendations on Monitoring During Anaesthesia*