FEEDBACK TO THE FIELD (FT2F) #1:

Misplaced Emergency Cricothyroidotomy Device *

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Original Release

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Misplaced Emergency
Cricothyroidotomy Device

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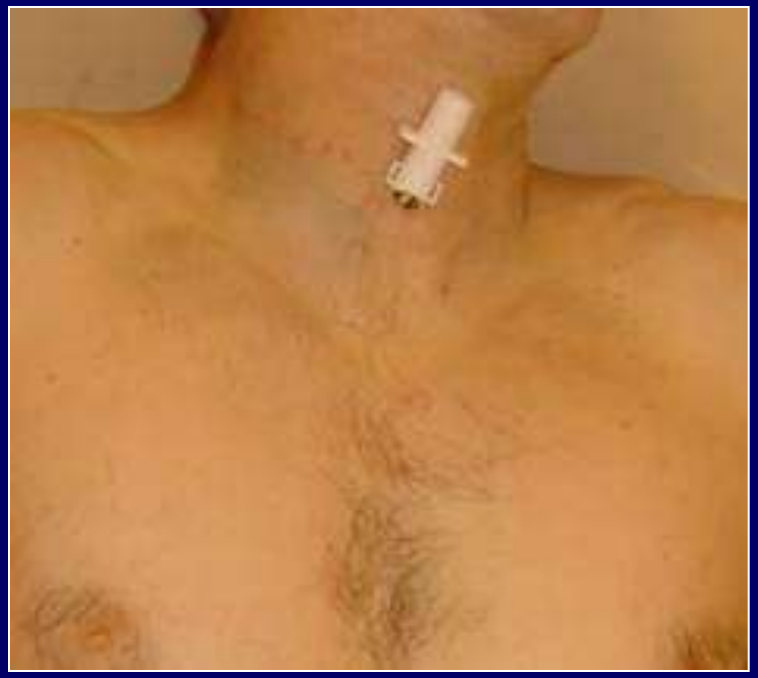
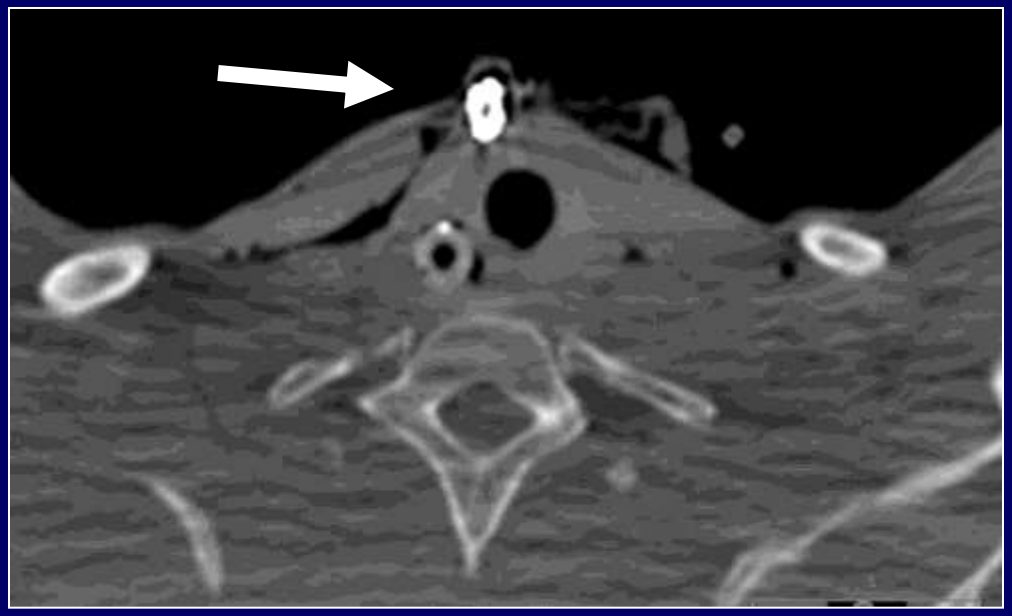
CASE OVERVIEW:

- Individual in a vehicle hit by an EFP
- Catastrophic injury to the lower abdomen and pelvis, to include transection of the abdominal aorta
- Emergency treatment included combitube, cricothyroidotomy device, sternal IO-IV
- Postmortem MDCT showed the cricothyroidotomy device outside the trachea, this was confirmed at autopsy

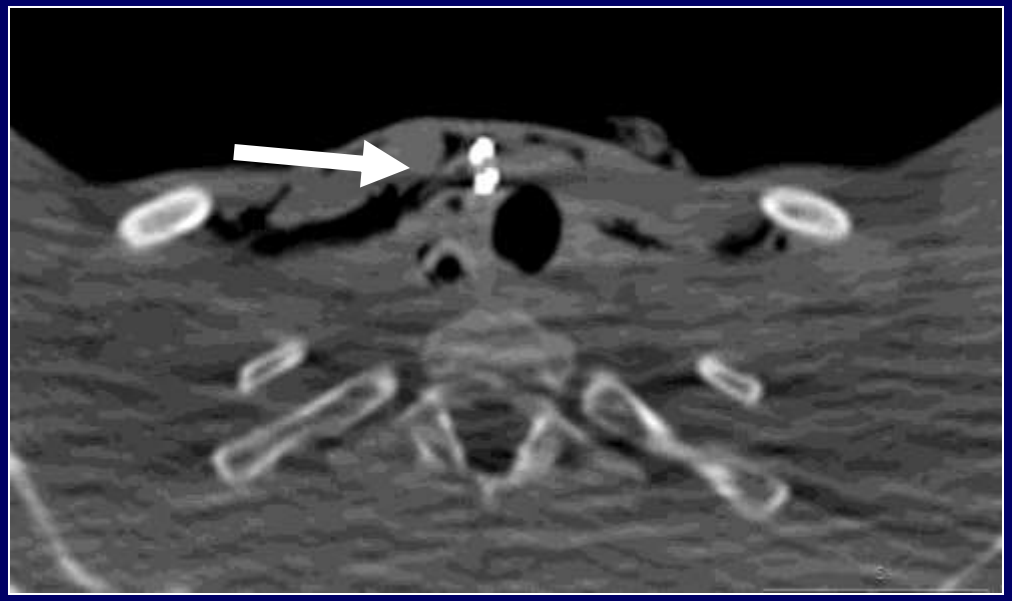


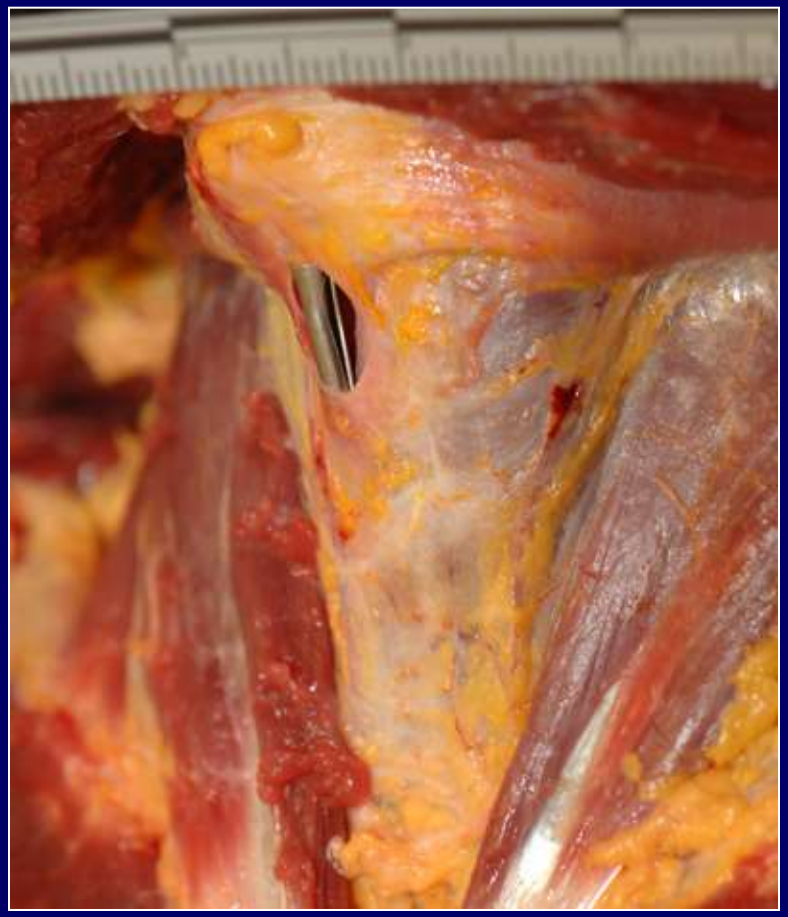
Cricothroidotomy device in situ at postmortem exam

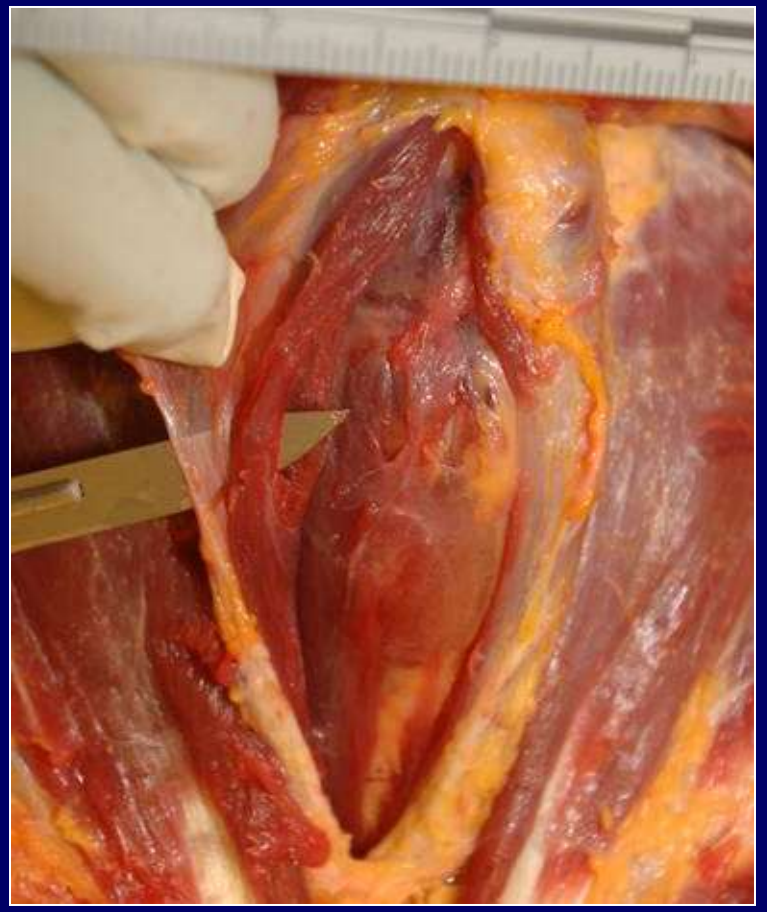
Postmortem axial MDCT images of the neck show the device outside the trachea (arrows).



Note combitube in the esophagus.

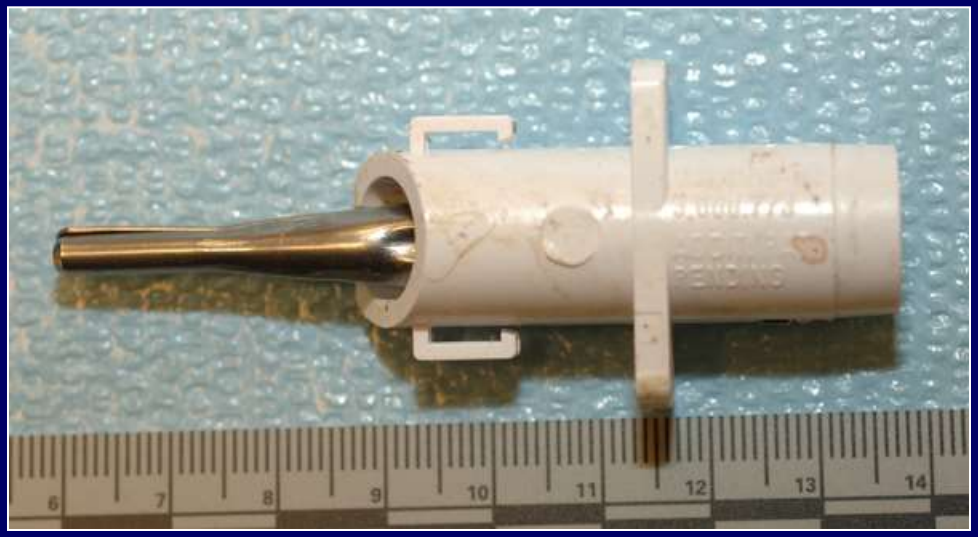


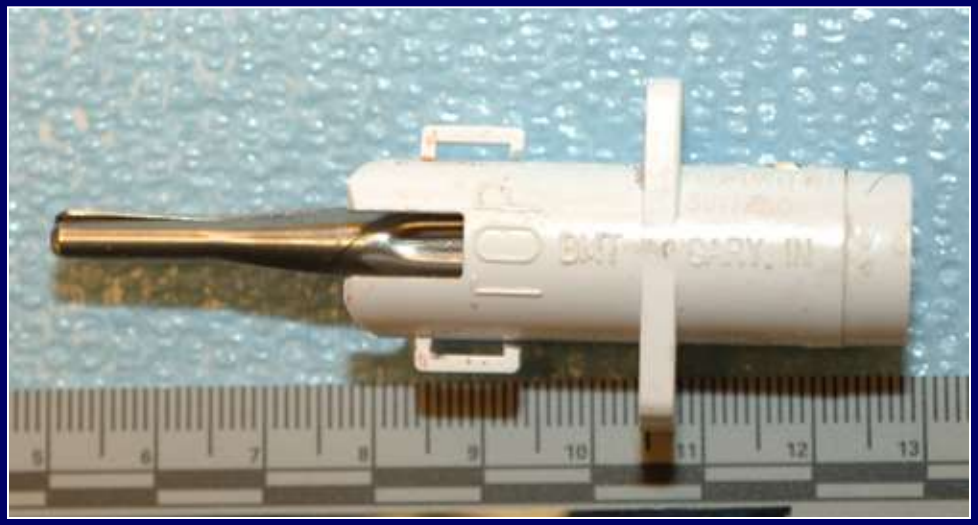




Layered neck dissection at autopsy confirms the device outside the trachea and shows entry point through muscle.

Cricothroidotomy device with airway cannula in place after removal





CAUTION:

The clinical circumstances and specific details surrounding the delivery of emergency treatment in this case are unknown.

This material is intended for educational and training purposes. If portions are extracted, the following statement must be included:

"Source: Armed Forces Medical Examiner System"

NOTES of CAUTION:

- The clinical circumstances and details surrounding emergency treatment in these cases is unknown
- This presentation makes no association between device placement and outcome of treatment
- This case series is drawn from cases with fatal injuries, which may skew data

For FT2F Comments / Questions / Requests:
Contact the Armed Forces Medical Examiner System (AFMES)

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