

- Many children with anterior mediastinal masses have a delayed presentation, often with respiratory embarrassment
- Failure to identify mediastinal compression may have catastrophic consequences if not recognized before intubation
- This guide aims to assist in the recognition, stabilization & transfer of children with symptomatic mediastinal compression
- Early discussion with PICU & Haematology / Oncology via the 1800 222 378 referral line is essential

Clinical signs & symptoms

Absence of clinical signs/symptoms does not eliminate risk of collapse

Signs of mediastinal Compression:

- Inc. WOB / ↑RR / Dyspnoea (ask older children)
- Orthopnoea** (ask/assess ability to lie flat)
- Wheeze / stridor** (may be positional/unilateral or may have new diagnosis of 'asthma'. **Stridor highly predictive of difficult intubation**
- History of: Cough (may be chronic), syncopal episodes
- Superior vena cava syndrome**
 - Face/neck swelling
 - Dilated veins in SVC distribution
 - Conjunctival injection
 - Check Pemberton's (raise arms above head=facial engorgement)

Signs associated with underlying disease

- Fever / night sweats/ weight loss
- Poor feeding / anorexia
- Lymphadenopathy / pallor

Key investigations

- CXR AP + lateral (may show widened mediastinum)
- Laboratory investigations:
 - FBC + Blood film
 - Blood gas
 - U&E inc. Creatinine /LFT/CRP
 - Uric acid + LDH

Additional investigations (if resources and time allow)

- CT thorax – **DO NOT** proceed if signs of mediastinal compression or if patient cannot comfortably lie flat
- ECHO - If formal ECHO unavailable, trained ED/ICU delivered point of care ultrasound (POCUS) can be extremely useful to assess for
 - Tamponade/pericardial effusion
 - LV function

For children with signs of respiratory/cardiac compromise, the priority is timely transfer to CHI for definitive care. If there is impending collapse this will be a time critical transfer & IPATS will not activate if >60min away from CHI

Initial stabilisation & management

Optimal positioning: Ask/watch child to assess preferred position – likely to be sitting up/favouring one side (may be prone)

Airway/Breathing: Level of support will depend on level of distress. Aim to keep O₂ saturations between 94% - 98%

- Mild distress/hypoxia – **HFNCC** 2L/Kg/min up to 15Kg or 30L/min if $\geq 15\text{Kg}$ as tolerated
- Moderate/severe distress / hypoxia – **NIV**. Start CPAP 3-4cmH₂O as tolerated. Titrate up as required/tolerated
- Intubation only indicated in life threatening respiratory failure due to high risk of cardiac arrest and/or complete airway occlusion. Outside of cardiopulmonary arrest - **Please discuss with PICU if intubation is felt to be required**

Circulation:

- PIV/IO x2. **Do not delay transfer for CVC/Arterial line insertion**
- Insert lines below the diaphragm where possible i.e., cannula in foot/Femoral CVC
- Fluid resuscitate if required – titrate 5-10ml/kg balanced crystalloid (Hartmanns) to effect
- Prepare adrenaline and noradrenaline infusions per local pump policy and have these connected to patient
- Prepare resuscitation medications/push dose pressors for transfer – see pre departure checklist for guidance

Other considerations:

- Some children will require IV Methylprednisolone – please discuss with CHI Haem/Onc Consultant before transfer**
- Keep NPO. Commence maintenance IVF as per policy or as directed by accepting CHI Haematology/Oncology Consultant
- Provide analgesia as required. Intranasal/IV fentanyl can be used safely in small aliquots for procedures if required

In case of impending collapse where intubation is deemed necessary

- Call for senior help. Call 1800 222 378 for ongoing PICU support during intubation if required
- Expect a difficult intubation and review paediatric DAS CICV guideline – see overleaf for link & prepare equipment
- Resuscitate before intubation** – have push dose pressors available + adrenaline running before induction of anaesthesia
- Awake fibreoptic intubation/Inhalational induction/Titrated Ketamine with maintenance of spont. Vent. are possible options
- In the event of life-threatening airway compromise, consider:
 - Repositioning – usually lying on the tumour side or prone
 - Rigid bronchoscopy
 - Waking patient and supporting with BiPAP for transfer

Respiratory Support tools



HFNC Hamilton Set Up Guide



NIV setup Guide
Respiro mask 3-20Kg



NIV setup Guide
MiniME2 >20Kg



Pre-Intubation
Checklist



Intubation Equipment
Sizing Guide



Invasive Ventilation
setup <15Kg



Invasive Ventilation
setup >15Kg



Paediatric
Ventilation Guide



DAS CICV Guideline

Critical Infusions

These infusions are a guide to those commonly used. Choice of medication, dose and route lie with the medically responsible clinician



NON- SCI
infusion table



CHI - SCI
infusion table



All medication
dosing/route information
can be found on the CHI
'Clinibee' app

CHI SCI Standard Concentrations PICU/Theatre: CONTINUOUS INFUSIONS AND LOADING DOSES (Version 4 Feb 2019)					Rate Calc (mL/hour)	Required Dose =	Default Rate (mL/hour)
Drug	Category	Weight Band	SCI (Normal)	Diluent	Usual Dose Range	Default Dose and Rate Calculator	
						Default Start Dose	Default Rate (mL/hr)
Adrenaline Central	Cardio	All ≤5kg	1mg/50mL	Glucose 5%w/v	0 - 0.2 microgram/kg/min	0.05microgram/kg/min	0.15 x Wt
		>5 - ≤10kg	3mg/50mL	NaCl 0.9%w/v			0.05 x Wt
		All >10Kg	6mg/50mL	Glucose 10%w/v			0.025 x Wt
Adrenaline (peripheral)	Cardio	All ≤10Kg	1mg/50mL	Glucose 5%w/v	0 - 0.2 microgram/kg/min	0.05microgram/kg/min	0.15 x Wt
		>10Kg	3mg/50mL	NaCl 0.9%			0.05 x Wt
Noradrenaline Peripheral administration can be as per Adrenaline	Cardio	All ≤5kg	1mg/50mL	Glucose 5%w/v	0 - 0.2 microgram/kg/min	0.05microgram/kg/min	0.15 x Wt
		>5 - ≤10kg	3mg/50mL	NaCl 0.9%w/v			0.05 x Wt
		>10Kg	6mg/50mL				0.025 x Wt
Midazolam	CNS	≤2.5kg	10mg/50mL	Glucose 5%w/v	Sedation:	1microgram/kg/min	0.3 x Wt
		>2.5 - ≤5kg	25mg/50mL	NaCl 0.9%w/v	0-4microgram/kg/min		0.12 x Wt
		>5 - ≤10kg	50mg/50mL	Glucose 10%w/v			0.06 x Wt
		10-20Kg	50mg/50mL				0.06 x Wt
		>20Kg	100mg/50				0.03 x Wt
Morphine	CNS	≤2.5kg	2.5mg/50mL	Glucose 5%w/v	Neonate:	20microgram/kg/hr	0.4 x Wt
		>2.5 - ≤5kg	5mg/50mL	NaCl 0.9%w/v	0-20microgram/kg/hr		0.2 x Wt
		>5 - ≤10kg	10mg/50mL	Glucose 10%w/v			0.1 x Wt
		10-20Kg	20mg/50mL		>1mth old:0-40microgram/kg/hr		0.05 x Wt
		>20Kg	50mg/50mL				0.02 x Wt

Frequently used intermittent medications

Doses for quick reference only – please prescribe using the CHI 'CLINIBEE' app or after direct consultation with accepting consultant

Fluid Bolus: Hartmann's Solution 5-10ml/kg

Ca Gluconate 10% w/v: 0.11mmol/kg (max 4.5mmol) (Target iCa of 1.2-1.4)

Hydrocortisone: 2mg/kg (max up to 100mg)

Phenylephrine Bolus: (5-20mcg/kg – max 500mcg)

Synchronised D/C Shock: 1-2J/kg

In case of cardiac arrest

Adrenaline IV/IO/IM: 10mcg/kg (0.1ml/kg 1:10,000)

Amiodarone – (VT/VF after shock 3&5) – 5mg/kg

Atropine – 20mcg/kg (min dose 100mcg, max 600mcg)

D/C shock – VT/VF: 4J/kg

AED – Paediatric attenuated if 1-8yrs / Adult >8yr

Useful Checklists & Resources



Stabilisation of
child in Adult ICU



PICU Referral
Tool



Pre-Departure
Checklist



P37 Activation
Guide

Time Critical Pre-Departure Checklist

Child with anterior mediastinal mass

To be completed by referring team prior to departure

Contact the accepting PICU intensivist via

1800 222 378 for advice during transfer

Airway / Ventilation Considerations

Child on NIV/HFNCC:

NGT inserted and attached to bile bag for drainage

Appropriate size intubation equipment available for transfer

HFNCC: Suggest 2L/Kg/min ≤15Kg, 30L/min if >15Kg

CPAP: Suggest starting at low PEEP 3/4cmH₂O for tolerance and inc. as required to PEEP of 5-7cmH₂O

Intubated Child:

Appropriately Sized ETT & NGT well secured

CXR performed & ETT & NGT position reviewed

ETCO₂ & O₂ sats visible on transport monitor targeting ETCO₂ 4.5-6Kpa & Sats 94-98%

Appropriately sized ETT suction catheters available (uncuffed ETT size x2 = Catheter French) i.e., 3.5 cuffed ETT has same internal diameter as a 4.0 uncuffed ETT ∴ (4 x 2) = 8 F suction catheter

If intubated, please ensure a blood gas (cap/ven/art) is measured once on transport ventilator.

Please use the IPATS oxygen calculator to ensure sufficient oxygen for the transfer



Circulation Considerations

It is always recommended that cardiac arrest medications are brought in addition to, and kept separate from, those suggested below

Working Vascular Access x2 (IV/IO)

Continuous ECG monitoring on transport monitor

NIBP set to auto q3-5min if no art line

Please do not delay transfer for art line insertion

Individualised approach to BP management.

Discuss targets with PICU before departure

Maintenance & rescue fluid available

Adrenaline and noradrenaline infusions

Prepared and connected to patient even if not immediately required.

If already on adrenaline infusion, prepare vasopressin as third line agent

Has discussion re need for methylprednisolone occurred and dose given if requested?

If patient is already on an inotrope – discuss with PICU re additional inotrope to bring on transfer

Push dose pressors: (to correct hypotension)

Choice & dose at discretion of medically responsible consultant.

1. Adrenaline 1:100,000

Add 1ml Adrenaline 1:1000 to 100ml NS = 10mcg/ml solution (label clearly)
Dose - 0.1ml/kg = 1microgram/kg per dose

2. Ephedrine diluted to conc. of 3mg/ml – as per Clinibee:

Dose – 1-12yr = 500micrograms/kg
Dose - >12yr = 3-7.5miligrams

IPATS Suggestion: Doses 100-200mcg/kg up to 3-6mg typically sufficient – Titrate with great care

3. Phenylephrine 100mcg/ml - as per Clinibee:

Dose - >1mo - 12yrs = 5-20micrograms/kg (max 500mcg)
Dose - >12yrs = 100-500micrograms

IPATS Suggestion: Doses 1-2mcg/kg up to 50-100mcg typically sufficient – Titrate with great care

Sedation / Neurological Considerations

Tolerance of NIV or procedural sedation:

If required, intermittent fentanyl 0.5-1mcg/kg or ketamine 0.25-0.5mg/kg can be administered.

Low dose infusions of same are also generally well tolerated if required

Suggested bolus CNS medications for transfer

Use & dose at discretion of medically responsible consultant.

Due to potentially delayed central circulation, please titrate doses and allow additional time for metabolism and eventual effect.

Have push dose pressor of choice available when administering any sedation bolus

Intubated Children:

Morphine 20mcg/kg/hr + midazolam 2mcg/kg/min suggested starting doses

Avoid propofol if any haemodynamic compromise

Recommended drugs for intubation include:

Ketamine 0.5-1mg/kg (titrated/repeated to effect)

Rocuronium 0.6-1.2mg/kg

+- Fentanyl 1-2mcg/kg (titrated/repeated to effect)

Further Reading / Resources

1. Anaesthesia for patients with Mediastinal Masses:

https://www.mcgill.ca/anesthesia/files/anesthesia/wk_5a_slinger_14_anterior_mass.pdf

2. Scrace B., McGregor K. Anterior mediastinal masses in paediatric anaesthesia. World Federation of Societies of Anaesthesiologists, 2015 <https://resources.wfsahq.org/atotw/anterior-mediastinal-masses-in-paediatric-anaesthesia/>

3.

4. Blank, R.S. and de Souza, D.G. (2011) 'Anesthetic management of patients with an anterior mediastinal mass: continuing professional development', *Canadian journal of anaesthesia = Journal canadien d'anesthesie*, 58(9), p. 853. [https://dokumen.tips/documents/anesthetic-management-of-patients-with.html?page=1](https://dokumen.tips/documents/anesthetic-management-of-patients-with-an-anterior-management-of-patients-with.html?page=1)

5. Leung, K.K.Y.^{1,2}; Ku, S.W.¹; Chigaru, L.³; Hon, K.L.¹. INTERHOSPITAL TRANSPORT OF CHILDREN WITH MEDIASTINAL MASS. *Pediatric Critical Care Medicine* 22 (Supplement 1 3S):p 125-126, March 2021. https://journals.lww.com/pccmjournal/Fulltext/2021/03001/P0205_1035_INTERHOSPITAL_TRANSPORT_OF_CHILDREN.264.aspx

6. Tan A, Nolan JA. Anesthesia for children with anterior mediastinal masses. *Paediatr Anaesth*. 2022 Jan;32(1):4-9. doi: 10.1111/pan.14319. Epub 2021 Nov 14. Limited access.

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Related Documents:	

The Irish Paediatric Acute Transport Service (IPATS) in conjunction has produced this clinical guideline with the PICU & Haematology departments in CHI. It has been designed for nurses, doctors and ambulance staff to refer to in the emergency care of critically ill children.

This guideline represents the views of IPATS and was produced after careful consideration of available evidence in conjunction with clinical expertise and experience. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient.