**BACKGROUND**

EXIT procedure (Ex utero intrapartum treatment), first performed in 1989, allows for controlled delivery and intrapartum assessment of fetuses with certain life-threatening conditions. By maintaining utero-placental circulation with only partial delivery of the infant, con-tinuous oxygenation is maintained allowing time to perform crucial procedures critical to infant survival. These procedures may include direct laryngoscopy, bronchoscopy, intubation, tracheostomy, tumor decompression and resection, or extracorporeal membrane oxygenation (ECMO) cannulation prior to clamping the umbilical cord. This paper reports the early experience of the recently established multidisciplinary unit at the University of Washington, Seattle.

**RESULTS**

To date 12 foetuses have been referred after antenatal ultrasound detection of suspicious airway pathology indicating an EXIT procedure. After multidisciplinary conference involving the parents EXIT was planned on 7 foetuses. Of these five had a cystic submandibular swelling with airway compression and two had arthrogryposis multiplex congenita. Although elective cesarean section was planned two were delivered emergently (premature onset of labor). Duration of the EXITs ranged from 10-64min. Foetal maturity ranged from 32-38weeks. Two breathed spontaneously and did not require intubation. The remainder but one were successfully intubated within 15min. One was successfully re-intubated after the initial airway established during EXIT was lost. Intubation could not be achieved in one before placental separation at 64 min. The airway anatomy was completely distorted by the massive cystic hygroma making intubation or tracheostomy impossible. This newborn was successfully intubated after spontaneous breathing was initiated and the “bubbles” from the airway could be followed.

General anesthesia, with or without epidural, was used for the cesarean section. Sevoflurane and nitroglycerin were combined to provide tocolysis while phenylephrine was used for blood pressure support and to maintain placental perfusion. Wound sepsis has been the only significant maternal complication.

**CONCLUSION**

EXIT procedures are expensive in terms of resources-booth personnel and equipment. They challenge the skills of the multidisciplinary team. Initial assessment based on imaging can provide misleading information. Careful planning (“team huddle”) is essential to achieve the goal of successful foetal outcome without maternal compromise. It remains unclear whether EXIT modifies ultimate outcome.