AIRWAY WORKSHOP

AIRWAY WORKBOOK A&P

RAPID SEQUENCE INTUBATION

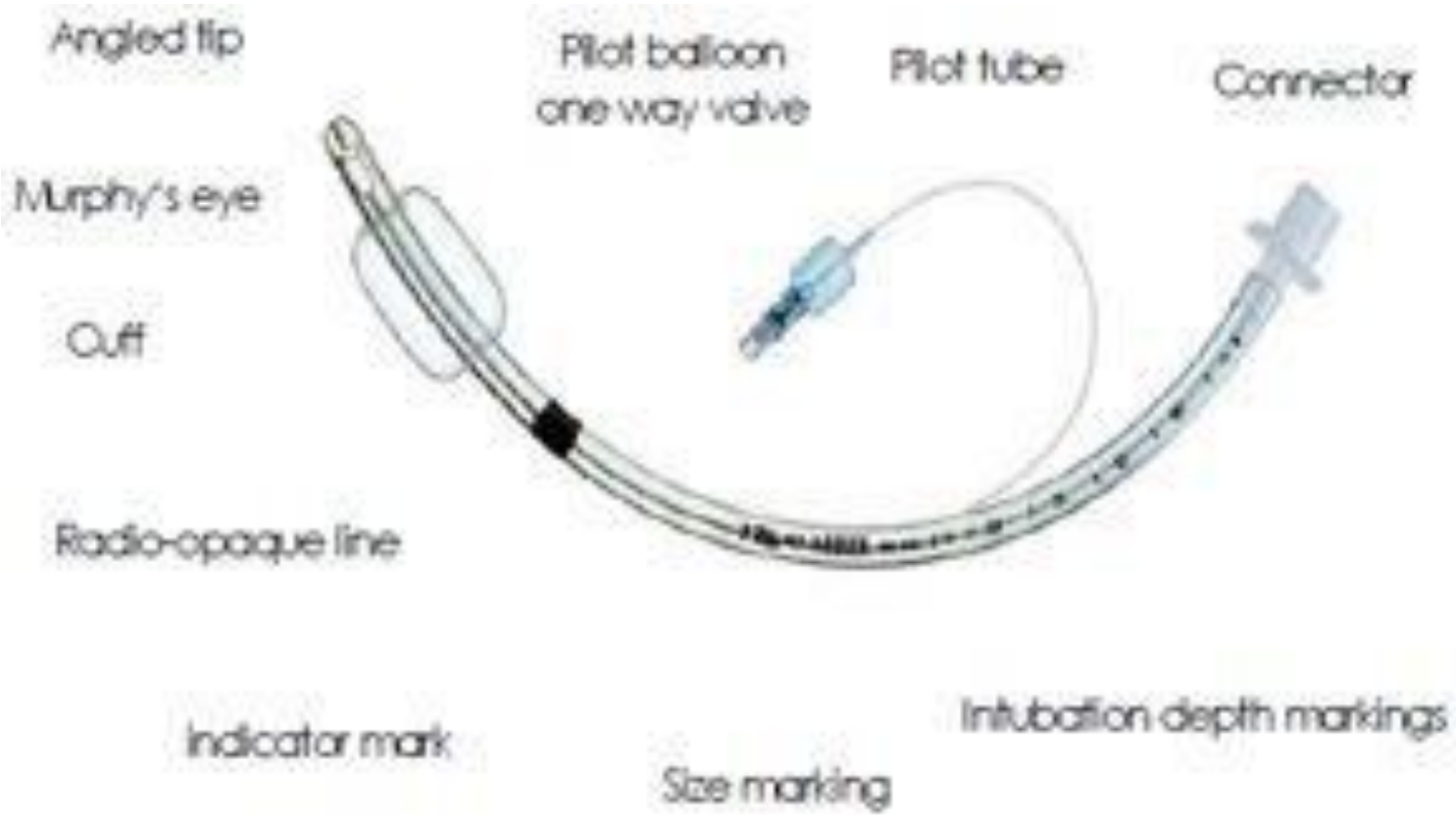
Be Prepared:

- S – suction
- O – Oxygen
- A – airway adjuncts
- P – pharmacy
  - Intravenous Access
  - Fluids attached
  - Emergency drugs available *(atropine, adrenaline, glycopyrolate, metaraminol)*

Monitoring:

- EtCO2** all intubated patient must have this as standard
- SpO2
- BP (arterial monitoring if possible)
- ECG

Endotracheal Tube



https://www.youtube.com/watch?v=0PQhseOdFNQ

- https://youtu.be/0PQhseOdFNQ
- Start from Pt prep section at 4:54 runs for 5mins

DIFFICULT AIRWAY

NAP4 (Critical Care):

- Nearly 20% (36/184) of all the airway incidents reported happened in ITU.
- Degree of harm higher than in anaesthetic or emergency departments.
- 70% of events & 60% of deaths – TRACHEOSTOMY

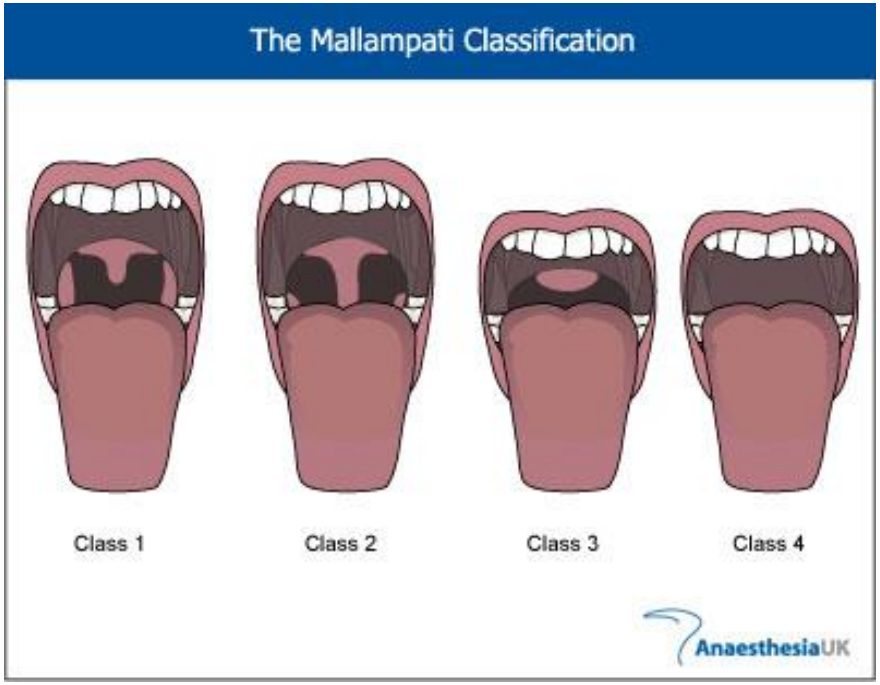
- Airways Comps identified:
  - **Unrecognised Oesophageal Intubation**
  - **Failed Intubation**
  - **Accidental Extubation**
  - **Haemorrhage**
  - **Transfer Problems**

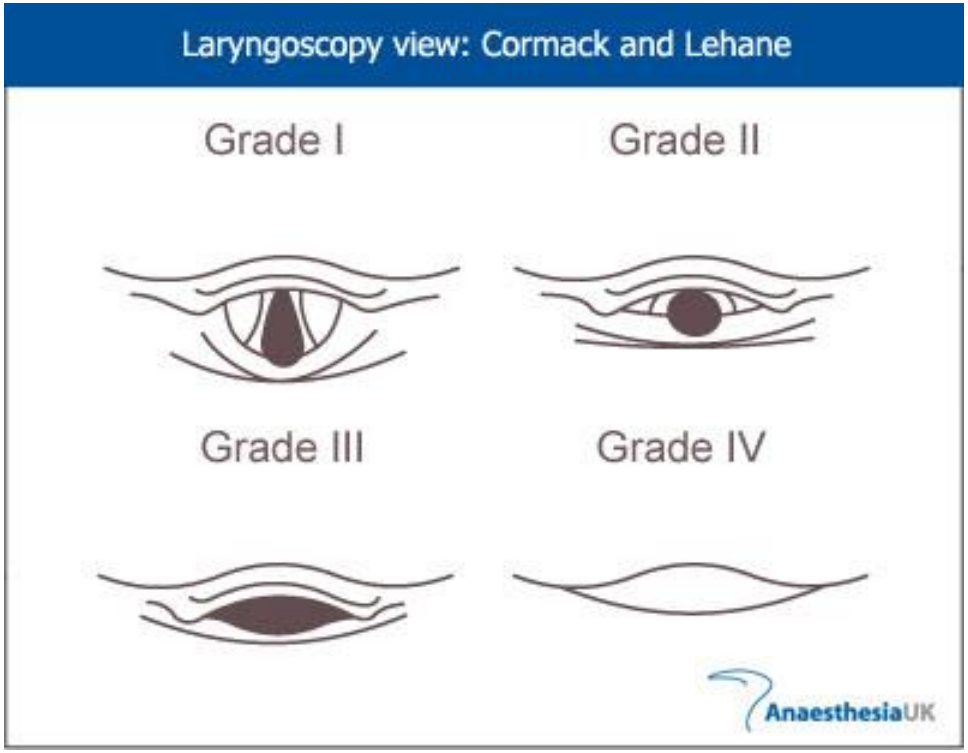
It is likely to be a difficult intubation if…..

- Multiple attempts at intubation attempts have been made (trauma to airway).
- It is worse if it is unexpected
- it is a failed extubation (due to swollen larynx)
- in notes says Grade 3 or 4.
- Obesity with a short neck
- Beards – can't see a receding jaw (which also makes intubation difficult)
- No dentures BVM difficult
- If patient snores – often difficult to use BVM

It is likely to be a difficult intubation if…..

- Patients with a stiff neck, can't open mouth, goitres, trauma, some congenital syndromes, tumour on larynx
- Mallampati scale (graded 1-4) to assess need to ask patient to stick their tongue out (see next slide)



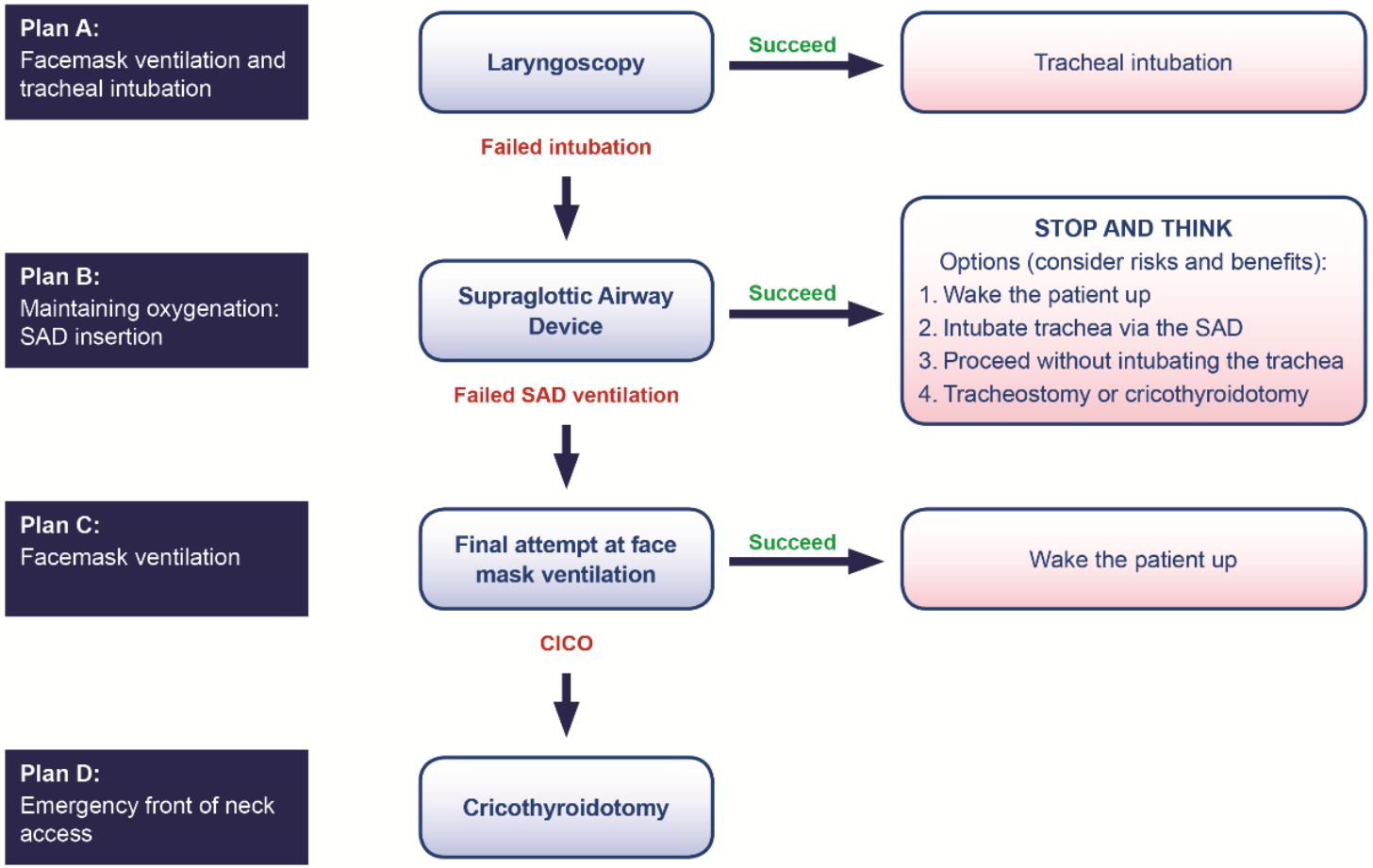

Laryngoscopy view: Cormack and Lehane
Grade I
Grade II
Grade III
Grade IV
AnaesthesiaUK

NAP4 Reccomendations:

- Plan A,B,C,D
- ETCO2 monitoring
- Standardised difficult airway trolley

DAS Difficult intubation guidelines – overview

2015



- 1st Oxygenate – Don’t fixate on attempting to get a tube in.

Plan A: Oxygenate

- 5-8 % of the time it is difficult to use a BVM with patients
- Consider:

❑LMA

❑iGEL (type of LMA)

❑Oropharyngeal airway

Plan B:

- MAX 3 attempts:
- Position the patients with the pillow ‘sniffing the air’
- Use bougie – some have a hole in the middle to connect to O2.
- Consider an alternative laryngoscope – Mc Coy blade the leaver allows the tip of the blade to move the epiglottis out of the way.
- Airtraq – load ET tube, look through

AIRTRAQ

Plan C: Advanced techniques

- Max 3 attempts:
- ??Intubate through LMA or bougie (with small size 5 or 6 tube) unlikely to be successful
- Fibreoptic scope – need to be well trained in this Glidescope (video)

https://www.youtube.com/watch?v=mIPjkp-BTHQ Run time 1:54

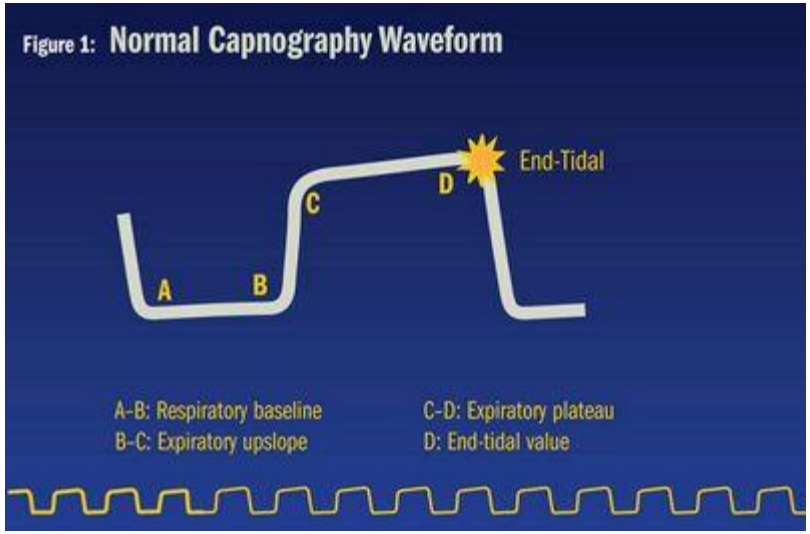
Plan D: Surgical Airway

- <1% who convert to surgical
- Cricothyroid - cannula and green oxygen tubing *** they don't stay in place very well
- Manujet (just gives O2 – won't remove CO2)
- Quick trach – incision through cricothyroid membrane

- Problems with all is poor ventilation, you can get the gas in but not out
- Patients may end up with surgical emphysema

Recommendations:

END TIDAL CO2 MONITORING FOR ALL VENTILATED PATIENTS



Recommendations:

DIFFICULT AIRWAY TROLLEY

DIFFICULT AIRWAY TROLLEY EXCERISE

WORKSTATIONS

Suction
Securing ETT
Bagging
Extubation