

Difficult direct laryngoscopy



Give 100% oxygen and maintain anaesthesia



Call for help

Step A Initial tracheal intubation plan when mask ventilation is satisfactory

Ensure: Oxygenation, anaesthesia, CPAP, management of gastric distension with OG/NG tube

Direct laryngoscopy – **not > 4 attempts**

Check:

- Neck flexion and head extension
- Laryngoscopy technique
- External laryngeal manipulation – remove or adjust
- Vocal cords open and immobile (adequate paralysis)

If poor view – consider bougie, straight blade laryngoscope* and/or smaller ETT

Succeed

Tracheal intubation

Verify ETT position

- Capnography
- Visual if possible
- Auscultation

If ETT too small consider using throat pack and tie to ETT

If in doubt, take ETT out

Failed intubation with good oxygenation

Step B Secondary tracheal intubation plan

Call for help again if not arrived

Insert SAD (e.g. LMA™) – **not > 3 attempts**

- Oxygenate and ventilate
- Consider increasing size of SAD (e.g. LMA™) once if ventilation inadequate

Succeed

- Consider modifying anaesthesia and surgery plan
- Assess safety of proceeding with surgery using a SAD (e.g. LMA™)

Unsafe

**Postpone surgery
Wake up patient**

Safe

Proceed with surgery

Safe

- Consider 1 attempt at FOI via SAD (e.g. LMA™)
- Verify intubation, leave SAD (e.g. LMA™) in place and proceed with surgery

Succeed

Failed intubation via SAD (e.g. LMA™)

**Postpone surgery
Wake up patient**

Failed oxygenation e.g. SpO₂ <90% with FiO₂ 1.0

- Convert to face mask
- Optimise head position
- Oxygenate and ventilate
- Ventilate using two person bag mask technique, CPAP and oro/nasopharyngeal airway
- Manage gastric distension with OG/NG tube
- Reverse non-depolarising relaxant

Succeed

Failed ventilation and oxygenation

Go to scenario cannot intubate cannot ventilate (CICV)

Following intubation attempts, consider • Trauma to the airway • Extubation in a controlled setting

*Consider using indirect laryngoscope if experienced in their use

SAD = supraglottic airway device