Technique for awake fibre optic intubation

The patient

- Informed consent
- IV access
- Non invasive monitoring
- Resuscitation drugs
- GA drugs
- Plan B in case of failure
- Calculate maximum dosage of lignocaine
- Sedation drugs which may be used -
  Midazolam 1-2 mg
  TCI Remifentanil 3 -5 ng/ml
  Propofol after confirmation of correct placement of endotracheal tube

The equipment

- Fibre optic scope 2.5 (paediatric) or 3.5 mm ID for nasal intubation or 4.5 (Storz) for oral intubations.
- Administer Oxygen 4L/min, to the opposite nostril using a nasal cannula (sponge plug with a central orifice for oxygen tubing).
- An epidural catheter may be used to deliver LA down the working channel of the scope. Tape it in place. Do not allow the tip to protrude beyond the scope – it will damage the mucosa.
- Load an ETT (5.5-6.5mm) reinforced tube over the bronchoscope and tape it loosely in place.
- Clean the tip of the scope with an alcohol wipe
- Focus & white balance the camera

Airway anaesthesia

(Avg wt-70 kg patient) (Some centres use up to max 9mg/kg of lignocaine)

General measures:

- Antisialagogue-Glycopyrrolate upto 200mcg IV
- Some recommend Nebulised lignocaine 4% 4ml(160 mg)
- Choose best nostril (sniff test)
- Communication with your patient throughout the procedure is of vital importance.
- Team communication with particular emphasis on experience of team members in difficult airway situation.
Nasopharynx:
- Either 2 ml of 10% cocaine via atomiser (20G Venflon, three way tap and oxygen) or 2 sprays of lignocaine with phenylephrine to each nostril (125 mg).
- Nasopharyngeal anaesthesia using gentle insertion of nasopharyngeal airway, surface soaked with 3-4 ml of lignocaine Instillagel (11 ml contains 230 mg of lignocaine).

Oropharynx:
- 2 sprays of 1% lignocaine to each tonsillar fossa (40 mg) if possible

Airway:
- Insert the bronchoscope and then lidocaine 1% via epidural catheter, spray as you go” up to 6 × 1 ml (60 mg). (Draw up the lidocaine in 2 ml syringes with 1 ml of air and inject forcefully). Usually 1-2 ml to the epiglottis, 1-2 ml to the vocal cords and 1-2 ml into the trachea will be sufficient.

Intubation
- Advance the scope to the carina
- Lubricate the inside of the tube with gel/1-2 ml Normal saline
- Advance the tube with gentle pressure and a continuous anticlockwise twisting motion
- Confirm tube position with the bronchoscope and end – tidal CO2 trace
- Secure the tube, induce anaesthesia and then inflate tracheal cuff

Pearls
1) If secretions are a problem ask the patient to cough and remove secretions orally with a sucker.
2) Fogging of the scope is often cleared by asking the patient to breathe deeply
3) The view is often improved by asking the patient to protrude the tongue
4) Everything red or white usually means the scope is touching the mucosa. Withdraw it until the anatomy is recognisable and start again. Keep within the air space and DO NOT ADVANCE THE SCOPE BLINDLY.
5) Some sedation will reduce the patient’s anxiety (and your own!) too much will cause trouble.
6) Remember to visit the patient postoperatively and document the patients experience in the anaesthetic record

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