AIRWAY PATHWAY - FOR GENERAL ANAESTHESIA AT CAESAREAN SECTION

KEMH GA CS Airway Pathway

Prepare
- Call DA and get DI trolley
- Acid prophylaxis
- Positioning (ear = sternal notch, ramp/oxford if > 100kg)
- PreO2 to Fetto2 >0.8* should not be excluded regardless of clinical urgency
- +/- Apply nasal prongs (O2 5-10L/min) and turn on after Fetto2 >0.8

Intubate
- C-MAC 3 (direct + indirect laryngoscopy) with cricoid pressure
- Consider bougie/BURP/reduce or release cricoid
- Max 2 attempts (3rd attempt if more experienced operator)
- Dedicate failed intubation (emergency bell + OT nurses to call DA)

Oxygenate (attempt both)
- Mask
- LMA classic
- Mask: 2 handed +/- OPA
- LMA: if fails, try alternate size/type LMA, max 2 attempts
- Reduce/ remove cricoid pressure

Front of neck access
- CICO pathway
- 1st line Cannula cricothyroidotomy
- 2nd line Scalpel-Bougie (if airway palpable) or Scalpel-Finger-Cannula (if airway not palpable
- See RPH CICO Algorithm

Successful ventilation
- Proceed with C/Section
- +/- cricoid pressure
- Limit fundal pressure
- Consider ETT pre/post fetal delivery *Rob with size 6 ML"

Borderline ventilation*
- Non urgent = Awake
- Urgent = Secure airway before C/S -ETT via LMA
- *post fetal delivery ventilation is likely to become easier

Originally developed by Sara Foroughi, Twain Russell and Ed Deborham 2013
This version approved by Sara Foroughi, Lip Ng and Scott Douglas 2015
AIM

This institution specific algorithm is designed to reflect local practices and equipment of the Department of Anaesthesia and Pain Medicine at King Edward Memorial Hospital for Women (KEMH).

BACKGROUND

The rate of difficult intubation is higher in the obstetric population versus the general population (1/300)\(^1\). The American Society of Anesthesiologists (ASA)\(^2\) and the Difficult Airway Society (DAS)\(^3\) algorithms are comprehensive airway algorithms, however they do not account for the obstetric population specifically. To date there have been several obstetric airway algorithms published\(^4-6\), but none have been entirely reflective of our local practices. Therefore an institution specific algorithm has been developed for KEMH.

KEY POINTS

The algorithm on the previous page highlights the following points:

- ‘Plan A’ – Prepare: highlights the importance of preparation in minimizing the morbidity associated with a difficult airway in obstetrics
- ‘Plan B’ – Intubate: refers to specific recommendations for optimising direct and indirect laryngoscopy for intubation
- ‘Plan C’ – Oxygenate: Oxygenation remains the most important priority at all points during the algorithm, but at this point it remains the only priority
- ‘Plan D’ – Surgical: This is an abbreviated form of what is taught at the Royal Perth wetlab for the management of Can't Intubate, Can't Oxygenate (CICO)

Repeated, frequent training of personnel is as equally important as the specific features of the institution specific algorithm\(^7\).

APPENDIX OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BURP</td>
<td>Backwards Upward Right Pressure (of thyroid cartilage)</td>
</tr>
<tr>
<td>C Mac3</td>
<td>Storz C Mac videolaryngoscope with Macintosh 3 blade</td>
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<tr>
<td>CICO</td>
<td>Cannot Intubate, Cannot Oxygenate</td>
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<tr>
<td>C/S</td>
<td>Caesarean Section</td>
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<tr>
<td>DA</td>
<td>Duty Anaesthetist</td>
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<tr>
<td>DI</td>
<td>Difficult Intubation</td>
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<tr>
<td>ETT</td>
<td>Endo-Tracheal Tube</td>
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<tr>
<td>etO(_2)</td>
<td>End Tidal Oxygen fraction</td>
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<tr>
<td>FOB</td>
<td>Fiber-Optic Bronchoscope</td>
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<tr>
<td>LMA</td>
<td>Laryngeal Mask Airway</td>
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<tr>
<td>MLT</td>
<td>Micro-Laryngeal Tube</td>
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PreO$_2$ Pre-oxygenation

REFERENCES (STANDARDS)

National Standards – 1.7.1 Agreed and documented clinical guidelines and / or pathways are available to the clinical workforce
Legislation - Nil
Related Policies -
Other related documents – Nil

RESPONSIBILITY

<table>
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<tr>
<th>Policy Sponsor</th>
<th>HoD Anaesthetics</th>
</tr>
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<tbody>
<tr>
<td>Initial Endorsement</td>
<td>April 2014</td>
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Access the current version from the WNHS website