ICU MANAGEMENT & PRACTICE

ICU Volume 7 - Issue 3 - Autumn 2007 - Matrix Feature

Failed Intubation in a Paralysed Patient

Author

Dr. Thomas Heidegger *(above)*

Consultant Anaesthetist

Quality Manager in Healthcare

Department of Anaesthesia, Walenstadt, Switzerland

thomas.heidegger@srrws.ch

Dr. Hans Joerg Gerig

Consultant Anaesthetist

Department of Anaesthesiology, Cantonal Hospital St. Gallen

St. Gallen, Switzerland

Research has amply demonstrated that the two most important tasks for the anaesthetist are management of the difficult airway and maintenance of oxygenation. Respiratory problems are still the most important single cause of anaesthetic adverse events leading to a bad outcome. The true number of these cases is likely to be significantly greater than those published. The question of what to do after failed intubation in the paralysed patient is a daily business. Thus, one could be forgiven for presuming that guidelines for its management are fairly standardised. Unfortunately, this is not the case. This article sets out some useful guidelines for practitioners to ensure best practice.

Should one be at a loss as to what procedure to follow after failed intubation in the paralysed patient, the first fundamental question is whether you can oxygenate the patient. If the answer is yes, you can consider your preferred technique on how to manage this particular problem. Deciding which supraglottic airway device is used should be based on the following parameters: 1. Clinical evidence;

2. Incidence of major and minor laryngeal morbidities;

3. Limitation in this special situation; and,

4. Availability, experience and hence preference of the user.

The key point is that only a sufficient range of proven techniques should be practiced every day to facilitate successful use in emergencies.

Failed Intubation – Different Recommendations

Recommendations of the different national societies differ significantly in their advice on best practice in managing an unpredicted difficult airway where oxygenation is still possible. In Table 1 you can see a few examples for comparison purposes.

Dealing with the Worst Case Scenario

If you cannot oxygenate your paralysed patient you will need guidelines and practice to avoid fatality. Despite the rarity of this scenario, it is the duty of the anaesthetist to know how to manage a ‘cannot intubate’ and ‘cannot ventilate’ scenario. In many cases, the disaster will have begun with a difficult mask ventilation and not directly with a ‘cannot intubate’ and ‘cannot ventilate’ situation. One of the most important reasons why this happens is that it has not been realised or accepted that this particular patient is impossible to intubate conventionally, and thereby the practitioner may continue to attempt intubation.

Table 2 shows different recommendations of how to manage a difficult mask ventilation that may potentially result in an airway disaster.

Conclusion

Despite the various recommendations published on how to manage a difficult airway, we must not forget that the steps involved in this critical treatment process will always be a practical matter that is subject to the individual variations of the situation. As anaesthetists and intensive care physicians, it is our obligation to gain and maintain the necessary skills, and to be prepared to manage rare life-threatening situations. As a consequence, the number of instruments should be limited to only a few proven techniques. These techniques should be used in the daily routine or at least in workshops.

Published on : Thu, 15 Aug 2013