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Can't Intubate, Can't Oxygenate in adults

We In Are Trouble But Don't Panic!!!

The "Can't Intubate, Can't Oxygenate" (CICO) scenario is a rare event with an estimated incidence of approximately 1:10000-1:50000 anaesthetics but may be more frequent in other specialties such as ICU or ED due to the patient case mix (NAP4 Sec2 Ch13). Although CICO is 'rare' over half of experienced anaesthetists report encountering this demanding scenario at least once in their career. It is therefore crucial to be as prepared as possible for such an eventuality.

In this teaching we are assuming that all supraglottic options have been attempted and failed. No patient should conceivably undergo attempts at emergency oxygenation through the anterior neck without having considered attempts at oxygenation through bag and mask ventilation, LMA insertion and attempts at intubation. NAP4: 60% CICO cases had NO attempt made at a SAD.

DAS Guidelines assume a **paralysed** patient. If unparalysed, consider laryngospasm and treat accordingly, consider if the patient can be woken up, giving a muscle relaxant at this point may enable ventilation and will possibly make surgical airway attempts easier.

Clear communication is a vital part of successful CICO procedure, both in communicating to the theatre team that a CICO event has arisen, and in achieving the correct series of steps necessary for a good outcome.

Needle Cricothyroidotomy has been removed from the current guidelines (Nov 2015) The important factor is the decision-making process and the communication.

Complications

- Malposition
- False passage
- Haemorrhage
- Oesophageal perforation
- Surgical emphysema
- Barotrauma / pneumothorax



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Surgical technique.

This enables placement of a size 6.0 and conventional ventilation.



Failed intubation, failed oxygenation in the paralysed, anaesthetised patient

CALL FOR HELP

Continue 100% O₂
Declare CICO

Plan D: Emergency front of neck access

Continue to give oxygen via upper airway Ensure neuromuscular blockade Position patient to extend neck

Scalpel cricothyroidotomy

Equipment: 1. Scalpel (number 10 blade)

2. Bougie

3. Tube (cuffed 6.0mm ID)

Laryngeal handshake to identify cricothyroid membrane

Palpable cricothyroid membrane

Transverse stab incision through cricothyroid membrane

Turn blade through 90° (sharp edge caudally)

Slide coude tip of bougie along blade into trachea

Railroad lubricated 6.0mm cuffed tracheal tube into trachea

Ventilate, inflate cuff and confirm position with capnography Secure tube

Impalpable cricothyroid membrane

Make an 8-10cm vertical skin incision, caudad to cephalad

Use blunt dissection with fingers of both hands to separate tissues

Identify and stabilise the larynx

Proceed with technique for palpable cricothyroid membrane as above

Post-operative care and follow up

- Postpone surgery unless immediately life threatening
- Urgent surgical review of cricothyroidotomy site
- Document and follow up as in main flow chart

This flowchart forms part of the DAS Guidelines for unanticipated difficult intubation in adults 2015 and should be used in conjunction with the text.

