

Department of Anaesthesia and Intensive Care

A technique for asleep fiberoptic intubation

This is useful for those situations where you are happy that you will be able to manage the airway (easy facemask ventilation) but where you need to have a nasal endotracheal tube in place for the surgical procedure.

The advantages of this technique over one that involves IV induction, muscle relaxation and endoscopic intubation are that the patient remains well oxygenated through the procedure, they maintain more muscle tone, the fact that they are self-ventilating makes the situation more like an awake intubation so is good for teaching purposes and there are fewer concerns about whether the patient is adequately anaesthetised during the procedure. The time pressure with a paralyzed patient is also removed.

- Prior to induction check which nostril is most patent- get the patient to sniff through each one and tell you which feels best.
- Gain IV access
- Keeping the patient in a head-up position, perform an inhalational induction with N₂O, O₂ and Sevoflurane.
- Spray some lidocaine and phenylephrine into both nostrils to act as a vasoconstrictor.
- Insert a size 4.0 RAE tube into the **least** patent nostril. Tape it to the patient's cheek.
- Connect the anaesthetic breathing system onto the RAE tube to maintain anaesthesia, oxygenation and deliver nasal CPAP to help maintain airway patency.
- Get an assistant (preferably another anaesthetist as the ODP still needs to assist you, or if you are the trainer, you need to assist the trainee intubator) to stand at the head end and provide chin lift and jaw thrust during the procedure.
- Pass the fiberoptic scope (with reinforced tube pre-mounted) into the most patent nostril. Guide the scope through the cords and visualise the carina.
- Get a third person (can now use the ODP) to hold the scope and maintain the carina in view whilst you pass the reinforced tube through the nostril, nasopharynx, oropharynx and cords. Constantly rotate the tube as you insert it to ease its passage through the nostril and vocal cords.
- Check how far above the carina the tube is sitting. To do this, pass the tip of the scope to the carina, grip the proximal part of the scope where it passes into the ET tube 15mm connector. Whilst holding this part of the scope, withdraw the scope until the distal tip of the ET tube comes into view on the screen. At this point, the distance between your fingers holding the scope and the 15mm connector is the distance of the ET tube above the carina. Adjust accordingly and re-check.
- Connect the breathing system onto the ET tube. Check for end-tidal CO₂ trace, inflate the ET tube cuff.
- Secure the ET tube onto the nose and face.
- Remove the size 4 RAE from the other nostril.