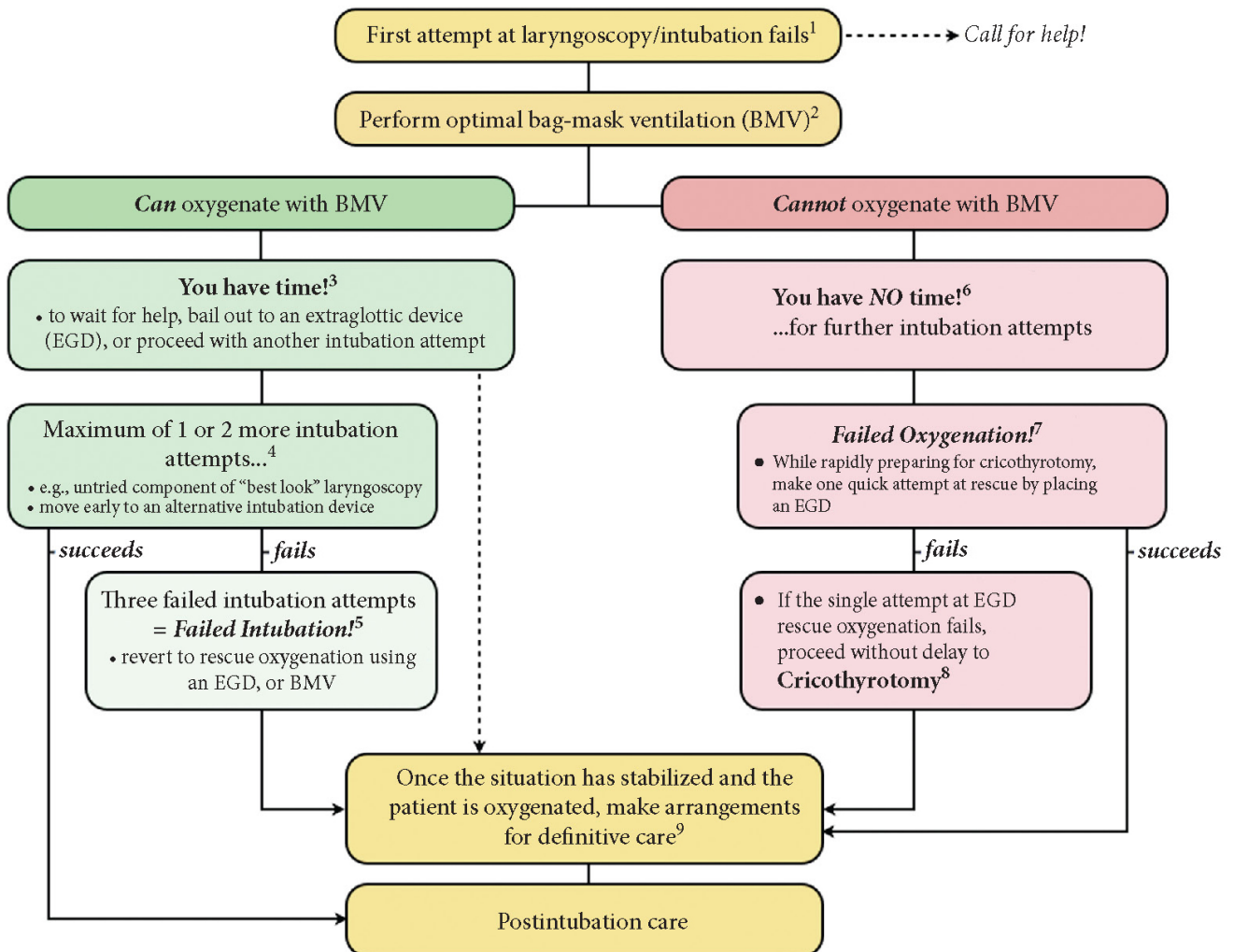


## Algorithm 2 The Encountered Difficult Airway.



1-All components of “Best Look” laryngoscopy should be performed during the first and any subsequent laryngoscopy attempt (Table 12-2). This includes adjunctive use of a tracheal tube introducer.

2-Optimal bag mask ventilation (BMV) includes use of an oral airway, jaw lift and two-person mask ventilation (Table 12-1).

3-As long as oxygenation is possible via BMV between attempts, you have time. Consideration should occur as to why the first attempt failed, and how chances of success can be increased during a second attempt. Alternatively, the primary clinician may elect to bail out and wait for additional help or equipment to arrive. BMV or an extraglottic device (EGD) can be used in the interim.

4-If clinician experience allows, a second attempt at intubation can be made. A blade change or untried component of “Best Look” direct laryngoscopy (DL) can be used, an adjunct such as a tracheal tube introducer (bougie), or an alternative intubation technique. If a third attempt is made, generally, it should be with an alternative to direct laryngoscopy.

5-In the “failed intubation” routine, the clinician should revert to BMV or place an EGD once it is evident that successful intubation is unlikely. This should occur after no more than three attempts at intubation.

6-If unable to intubate and unable to oxygenate the patient, there is no time for further attempts at tracheal intubation.

7-In the “failed oxygenation” routine, the default action is cricothyrotomy. However, while preparations are being made for the cricothyrotomy, a single attempt at placement of a rescue EGD should occur.

8-Cricothyrotomy may be performed by open surgical, or percutaneous, needle-guided cannula techniques.

9-Definitive care must be arranged, by obtaining additional equipment, expertise from colleagues, or transferring the patient.