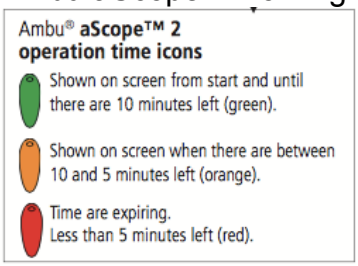
ADVANCED AIRWAY Currency 1.2

KING VISION	
Indications for Video Laryngoscopy in Interhospital missions	Difficult laryngoscopy - as alternative or first choice laryngoscope per operator preference. Expected easy laryngoscopy for familiarity. Awake (topicalised/sedated) laryngoscopy – note large surface area of channeled blade makes CMAC D blade (or similar) preferable for awake look.
Location	Green interhospital – advanced airway pouch. Disposable channelled blade x 2 (adult size 3 for ETT sizes 6.0-8.0mm) & non-disposable OLED screen
Power source Low battery indicator top left of screen	3 x AAA batteries – spares in case Green is good, flashing red means replace batteries before use
Assembly & Use	Blade into screen THEN turn on screen Preload ETT 7.0 parker tip (RSI/PHEA airway packs) into lubricated channel – do not extend beyond camera/channel Manually open mouth for insertion – suction oral cavity – place onto tongue then watch screen as blade advances Insert either into vallecula or lift epiglottis directly whichever produces best view of cords. Place cords in centre of screen and advance ETT through cords. Unload the ETT laterally from side of channel then remove King Vision from mouth.
Prerequisites	Mouth opening for a-p diameter 18mm RSI checklist - team brief to include laryngoscopy plan If awake – adequate topicalisation/sedation of tongue and oropharynx +/- glottis.
Troubleshooting Screen-freeze Handle hits on chest wall Mouth not wide enough Can't see cords – too bright? Blood on camera ETT not aiming towards cords Larynx too anterior	 Reconnect blade to handle and turn off/on Insert handle 90^0 (towards ear) or connect screen once blade in mouth or ramp patient/extend neck Open jaw manually then insert Sun shade Remove, clean camera with alcowipe & suction airway before re-insert Pull handle towards yourself (against hard palate) and upwards (anterior) to make space & place cords in middle of screen with rotation/tilt. Aim for glottis to take up <50% of screen (Distant view better than too close) Tilt handle (pulling pint), ELM, or use bougie through ETT or separately along channel. Bougie with coudé tip needs shaping to King Vision channel shape prior to use.
Turning off	Auto turn off after 60s lying still / Disconnect blade & screen auto-off 20secs / press & hold on/off button
Cleaning screen	Cleaning wipes – avoid liquid entering battery compartment

AMBU ASCOPE2	
Indications for Flexible scope in Interhospital missions (D/W DRC)	Awake (topicalised/sedated) endoscopy – nasal or oral e.g. airway assessment Awake (topicalised/sedated) intubation – nasal or oral e.g in poor mouth opening; risk of airway loss with RSI. Intubation via iGel after failed intubation with optimised attempt at laryngoscopy +/- video laryngoscopy.
Possible contraindications (D/W DRC)	Haemorrhagic/pus pharyngeal lesions – risk fluid rupture obscures camera Laryngeal trauma – risks tracheal disruption Stridor/obstruction – risk scope occludes airway
Location	Green interhospital pack – advanced airway pouch. Plastic screen protector for storage – remove for use. Single use Scope x 2, Monitor x 1, mains plug x 1. 6.0 reinforced/flexible ETT x 2
Power source Low battery indicator	Plug in to mains (battery will be flat) On screen red plug icon – low battery but plugged in On screen red battery icon – low & not plugged in
Technical bits	Ambu aScope 2 working life 8 hours  Cord 5.4mm width, 630mm long, 120^0 flexible tip, focal depth 2-50mm smallest ETT 6.0 (fits through iGel 3 or over) 0.8mm working channel – max O_2 flow rate 2.2lpm
Assembly	Place screen on firm surface & plug in to mains. Plug ambuscope into front of screen. Turn on screen and scope. Adjust brightness & contrast as needed. Lubricate scope and load 6.0mm flexible ETT. Check & lubricate cuff.
Feng shui	Consider arrangement to allow one person to clearly see vital signs monitor, patient and acts as airway assistant, while other focuses on airway manoeuvre. Adjust height of bed +/- operator on step. Patient semi-sitting vs lying.
Prerequisites	Co-operative & oxygenated adult patient – explain actions & local tastes horrible RSI checklist & awake intubation checklist completed especially team brief. D/W DRC.
Awake oxygenation options	Other nostril, mouth, cricoid puncture
Awake Topicalisation doses Drying agent (to enhance local anaesthetic action) Vasoconstrictor (reduce nasal bleeding)	 Glycopyrrolate 4-5mcg/kg iv or Atropine 10mcg/kg (600mcg iv) Co-phenylcaine (phenylephrine & lignocaine = 5mg lignocaine per squirt – 6 squirts per nasal cavity)

Local anaesthetic	Lignocaine airway mucosa topicalisation maximum dose 9mg/kg (630mg in 70kg patient). Note nebuliser 8ml 2% lig = 160mg; 1ml 2% lig via MADJIC/aScope = 20mg. MADJIC to nose/back of tongue/oropharynx/glottis +/- via split NPA onto glottis. SAYGO spray as you go 1ml 2% lignocaine x 2 via working channel to cords & trachea pre intubation
AFOI procedure	After checklists, topicalisation & oxygenation ensured. Further lignocaine aliquots with air prepared. Insert split NPA as nasal conduit; consider bite block with oral conduit. Hold scope straight (statue of liberty pose) Spray cords/trachea before advancing through them safe distance (see carina usually). Railroad ETT with twisting motion. Hold firm as withdraw scope (patient may cough/move significantly). Confirm placement with visualising ETT as withdraw & $ETCO_2$ before sedation/paralysis given. Confirm tracheal placement (not R bronchus) & secure++ If confident – assess distance from ETT tip to carina Elastoplast trouser taping (paeds technique) to nose/mouth useful.
Sedation – pros/cons (mostly turbinate pain & anxiety)	Explanation & reassurance best drug. Apnoea & respiratory depression needs to be avoided. Maintain oxygenation, safety & co-operation. Small aliquots repeated always preferable to large doses. Ketamine has proven useful in this service; fentanyl & midazolam aliquots widely used elsewhere
Asleep iGel considerations	Adequate sedation & paralysis (no topicalisation required) Ventilate with PEEP via iGel to pre-oxygenate before attempt. Note nasal cannulae oxygen not helpful whilst LMA in situ. Once ETT railroaded to hilt – confirm tracheal $ETCO_2$, inflate cuff, trouser tape ETT to iGel and secure iGel to patient.
Troubleshooting Blurry image/soiled camera	Tongue or alcowipe cleans well. ETT suction catheter.
No oropharyngeal space	Protrude tongue (patient or assistant) to reveal epiglottis & cords.
Scope tip not twisting	Hold scope straight to twist tip
Screen blurred after lignocaine	Leaky scope camera – exchange scope
ETT hold up at cords/arytenoids	Dis-impact (withdraw 1-2cm) then rotate continuously as advance
ETT in R bronchus	Adjust afterwards as normal.