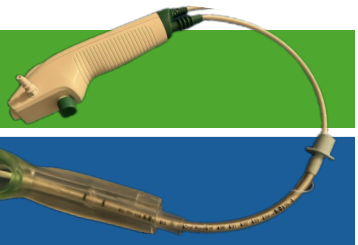
INTUBATION THROUGH LMA



Consider Other Options
- Optimised RSI (VL) +/-FOI
- Surgical Airway
- Transport with LMA in situ

DISCUSS WITH DRC via ACC or 9709 6856

If non-iGel LMA in situ test suitability as conduit for intubation

Feed 6.0 R ETT through same make/size LMA -> 2 black lines on ETT protrude

CONSIDER CHANGING LMA TO iGEL

SET-UP
Aview plugged in & positioned in eyeline of intubator at head end
Ascope 5.0 connected, check flexion & picture, lube lightly
6.0 flexible ETT – cuff fully deflated and lubed
Assistant & team briefed – role allocation
RSI checklist & equipment available
Team brief including lowest SpO_2 & failed intubation plan
PROCEDURE
PreOxygenate on 100% FiO_2 ventilated with PEEP
Ensure relaxant & sedation
Press record on work phone/aView
Insert flexible 6.0 ETT into LMA lumen (max 17cm for IGEL #4)
Insert Ascope through ETT, adjust LMA if needed for larynx exposure, pass cords and go towards carina
Railroad ETT to hilt -> remove ascope visualizing ETT in trachea
Inflate ETT cuff & confirm $ETCO_2$ waveform
Note ETT depth & secure both LMA and ETT
Consider gastric tube via gastric port (12F in IGEL #3or4)
Consider giving spare 6.0 flexible ETT & video to receiving hospital