Short title: Difficult airway equipment

1. Purpose

The purpose of this guideline is to:

1.1 identify equipment that may be required to manage difficult airways in all clinical areas where airway management is undertaken.

1.2 provide an important up-to-date resource for the procurement of difficult airway equipment.

1.3 standardise and simplify the choice of difficult airway equipment to enhance familiarity while reflecting the skill sets of clinicians with a broad range of clinical experience working in differing clinical environments and jurisdictions/countries.

2. Scope

This document is intended to apply to all areas where difficult airway management may occur including adult, paediatric and obstetric anaesthesia environments, intensive care units (ICU), and emergency departments (ED). Also included are stand-alone day surgery units and clinical areas utilising patient sedation such as gastroenterology units, radiology departments and cardiac catheter units. Both public and private facilities, including small stand-alone single procedural rooms, are considered. Finally, the document considers the diverse requirements encountered from tertiary through to remote healthcare centres.

3. Background

Airway assessment is fundamental to identifying the risk of a difficult airway but is not always predictive. It is therefore, imperative that the necessary difficult airway equipment is readily available and accessible wherever airway management occurs.

This document and the accompanying background paper provides evidence-based recommendations for equipment that should be stored in difficult airway trolleys (DATs) throughout all clinical areas in Australia and New Zealand.

An important aspect is the emphasis of a consistent set of essential components on every DAT. This includes facemasks, supraglottic airways, direct and videolaryngoscopes as well as equipment for emergency front of neck access (eFONA). Although refinement is required to ensure that DATs are fit for purpose in each allocated area, standardisation of these essential components addresses human factor issues during crises.

Ideally, equipment choice should be simple in order to facilitate decision making yet not oversimplified to the point of omitting key equipment. In this regard, ANZCA's support of the "Airway leads" role is timely as these leads are tasked with ensuring that their DATs are fit for purpose. The recommendations within this guideline are meant to be contemporary as well as forward looking to accommodate future airway management development. Difficult airway management is a rapidly changing area. It is expected that airway leads will manage procurement and training for all new equipment.

Important features beyond equipment are considered including critical appraisal of cognitive aids, difficult airway management algorithms, labelling of drawers and general design features. These

recommendations complement the equipment guideline and provide a complete package for DAT development. Ultimately, DAT equipment procurement and management falls under the care of those who use it. This current review is intended to form a foundation for all DATs throughout Australia and New Zealand. A collaborative approach over time, across all relevant specialities and geographical locations will enhance the impact of this guideline as a resource for patient care.

Prescriptive guidelines are inappropriate when there is a wide range of clinical settings in which airway management occurs. An authoritative document, however, has the benefit of providing practitioners with a suitable resource that address all these areas while making “real world” recommendations to promote patient safety.

The accompanying background paper provides comprehensive details and literature-based justifications for inclusion of recommended items.

4. Recommendations

4.1 Appointment of “Airway leads”, individuals with an interest in airway management, education, training and resources, will assist in enabling choices of equipment that align both with this document and local requirements.

4.2 **Difficult Airway Trolleys**

Difficult airway trolleys are containers for storage of resources to manage difficult airways.

4.2.1 Equipment for DATs should:

- be fit for purpose
- be standardised throughout all clinical areas in a facility
- allow for redundancy and a culture of safety
- be familiar to all personnel working in the critical care area
- meet recognised infection control guidelines, ANZCA *PG28(A) Guideline on infection control in anaesthesia*
- be supported by the immediate availability of capnography wherever airway management occurs.

4.2.2 Difficult Airway Trolley Design

Equipment on DATs should be organised in such a way that it is immediately recognisable and accessible for all clinicians involved in managing airways or assisting in airway management. Additional equipment may form part of the trolley when clinicians are skilled in its use.

DATs should be lightweight and highly manoeuvrable so that they can ideally be taken to any point of care within 1 minute. Bulkier items such as flexible bronchoscopes with associated monitors may be on a separate mobile stand.

Overall design features of ideal difficult airway trolley

Feature	Comments
Suitable signage over DATs	Allow easy and rapid identification of DATs to all personnel
Easily cleaned	
Core elements are standardised and recognisable throughout critical care areas where airway management is undertaken (for example universal trolley design throughout hospital) while non-core elements reflect the requirements of specific critical area	Evolution of “universal trolley” throughout critical care areas – easy recognition of core equipment within DATs while preserving features of DATs that reflect the specific clinical needs of patients in the critical care area (for example patients in intensive care, emergency medicine and anaesthesia)
Easily manoeuvrable Low centre of gravity Light weight construction High quality wheels Large side handles	Steel DATs are heavier and not recommended
Large procedural area	Space for opening flexible bronchoscopes, videolaryngoscopes and front of neck access (FONA) equipment and so on.
4-7 drawers	Number of drawers related to amount and size of equipment required in designated area
Soft close drawer system	Must close fully but remain unlocked
Vertical containers	Hold longer devices that can’t be folded

The location of DATs should be clearly indicated by signage, as should their temporary relocation when used. Airway leads should have a significant role in deciding the number and location of DATs.

The contents of each drawer should be clearly labelled with printed and, ideally, pictorial labels (see resource) to facilitate rapid and accurate access. As well as a series of drawers, vertical containers on the side of any DAT will hold ancillary devices such as airway exchange catheters and introducers.

Sugammadex may be considered for a limited number of difficult airway management scenarios and should be available in a secure but easily accessible (unlocked) location close to, but not necessarily in DATs.

It is recommended that several resources are attached to all DATs:

- Guidelines / flow charts for management of the difficult airway developed by expert bodies
- Cognitive aids
- Checklist of content audit
- Emergency contact telephone numbers
- Template difficult airway alert letter

Equipment to be included in DATs is presented in Appendix 1 for adult patients and Appendix 2 for paediatric patients. Equipment to be included in rapid deployment kits (grab bags) is presented in Appendix 3 for adult patients and Appendix 4 for paediatric patients.

4.3 Airway Equipment

4.3.1 Facemasks

Facemasks need to be light weight, transparent with minimal dead space and contoured to provide a good seal. Most currently in use are single-use with an inflatable air cushion or moulded. It is essential that design and quality ensures that oxygenation and ventilation are effective.

4.3.2 Self-inflating Resuscitation Bags

Self-inflating resuscitation bags fitted with PEEP valves and bacterial/viral filters are essential wherever airway management occurs and should be a component of the “grab bag” for airway management in any area of a healthcare facility. Where these are supplied as a single unit the ability to readily separate the mask should be confirmed.

4.3.3 Supraglottic Airway Devices

The evolution of supraglottic airway devices (SAD) has seen the inclusion of varying design features including gastric drainage channels, higher seal pressures, wider airway channels, fixed curvature, bite blocks and enhanced intubation capacity. The variety of these “second generation” SADs is significant and constantly expanding. Choice of device for DATs should reflect those in regular use within the healthcare facility. Second-generation SADs that provide for easy passage of a flexible scope to allow endotracheal intubation should be available.

Classic design first-generation SADs in a range of sizes should continue to be available in DATs as they have lower profiles and, on occasions, improved ease of insertion. While second-generation SADs are preferred in many difficult airway algorithms, their placement may be problematic in some patients. It is therefore, suggested that as an alternative, first-generation SADs may have higher success rates of insertion and improve patient oxygenation when critical desaturation has occurred.

4.3.4 Laryngoscope Blades

Although anaesthesia machines or trolleys hold commonly used laryngoscopes and blades, it is important that DATs have replicated equipment considered essential for airway management. Thus, they should contain size 3 and 4 Macintosh blades and handles.

The increasing availability and use of videolaryngoscopes has influenced the value and frequency of use of other blades. Straight and McCoy laryngoscope blades are not required in DATs unless operators have been trained in their use and have an ongoing volume of practice.

Currently there are no videolaryngoscopes with short handles commercially available. Short handle laryngoscopes may be useful for managing patients with a large antero-posterior chest diameter (e.g. “barrel” chest, pregnant patients and bariatric patients with large breasts). It is therefore, recommended that a short handle laryngoscope should be included in DATs.

Where paediatric patients are managed, Macintosh blades sizes 1, 2, 3 and 4 and straight blades, such as Miller blades, sizes 0, 1, 2 should be included in DATs.

4.3.5 Tracheal Tube Introducers, Bougies and Exchange Catheters

Tracheal tube introducers and bougies have a place in difficult intubation, difficult extubation, placement of second-generation laryngeal mask airways and cricothyroidotomy. It is recommended that tracheal tube introducers and bougies with a 35 degree Coudé tip or a steerable tip should be included.

Airway exchange catheters 11Fr and 14Fr should be included and stored, unfolded. Airway exchange catheters are important tools when exchanging tracheal tubes or as part of an extubation technique. However, it is essential that clinicians are aware of the risks associated with the use of such catheters.

Intubating Catheters are used in association with flexible bronchoscopes to aid intubation through supraglottic airways, or occasionally for endotracheal tube exchange. Consequently, they should also be included and stored, ideally in a straight position.

Paediatric exchange catheters in a range of sizes, and introducers should be included in paediatric DATs.

4.3.6 Endotracheal tubes

Cuffed tracheal tubes ranging from 6.0 to 8.0mm internal diameter and microlaryngoscopy tubes 5.0, and 6.0mm internal diameter should be stored in DATs.

In facilities where children are managed, cuffed and uncuffed paediatric tracheal tubes ranging from 2.0 through to 5.5 mm internal diameter should be included.

4.3.7 Videolaryngoscopes

Videolaryngoscopy has been shown to increase first pass success rate of intubation, reduce the number of failed intubations (particularly among patients presenting with known or predicted difficult airways), improve glottic view and reduce airway trauma. However, at this time there is no evidence that videolaryngoscopy reduces the time to intubation, incidence of hypoxia or respiratory complications.

It is recommended that both Macintosh style and hyperangulated blades are available in all DATs so that a wide range of difficult airways may be successfully managed. Tracheal tube introducers suitable for each type of videolaryngoscopy blade should also be available.

4.3.8 Front of Neck Airway Access

In case of inability to intubate and oxygenate any patient, it is essential that equipment for emergency front of neck access (eFONA) be immediately available wherever airways are managed and on all DATs. eFONA kits should contain equipment for both the scalpel/bougie technique and cannula technique but whichever is selected should reflect the training of clinicians who may be required to perform infraglottic airway access. As clinicians move between institutions, both should be available.

Each institution should have local protocols and procedures in place supporting a limited number of devices with regular training in their use.

Ancillary equipment should also be attached to or stored in DATs including algorithms. Oxygenation devices may be included but an understanding of their indications, mechanism of action and pitfalls is essential.

4.3.9 Paediatric Airway Equipment

The same principles that apply to adult airway management equipment also apply to paediatric equipment including accessibility, standardisation, regular checking and training.

Ideally, equipment to manage difficult paediatric airways should be stored in dedicated paediatric difficult airway trolleys (Paed DATs). It should be suitable for the range of ages and sizes of patients undergoing care in the facility. This may range from neonatal to large adult size patients.

SADs are essential tools for management of difficult paediatric airways; function as primary ventilation airways; and serve as conduits for tracheal intubation and rescue ventilation devices. Videolaryngoscopes are useful for children and their availability with smaller blades also makes them an important tool for managing the difficult neonatal airway. Flexible bronchoscopy with a swivel connector connected to a SAD is particularly useful in infants.

Equipment for eFONA should be available.

4.3.10 Obstetric airway equipment

No new or alternative equipment is required for difficult airway trolleys for use in obstetric settings apart from considerations of optimal patient positioning using pillows/foam bolsters for ramping. Videolaryngoscopy is recommended as first line when intubating. SADs should allow easy passage of an endotracheal tube.

4.3.11 Difficult airway equipment for intensive care

Airway management in ICUs may involve time-critical airway procedures in deteriorating patients with multiple co-morbidities. As intensive care patients generally have limited physiological reserve and are often not fully conscious or cooperative, rapid sequence or modified rapid sequence intubation may be required. This has direct implications for the type of rescue devices and techniques used, as waking up any patient when difficulty is encountered is rarely an option.

Recommended devices include a range of SADs, Macintosh-style and hyperangulated videolaryngoscope blades, flexible bronchoscopes, as well as equipment for a surgical airway. In addition, specialised tracheal extubation equipment is often required.

4.3.12 Difficult airway equipment for emergency departments

Patients requiring intubation in emergency departments (ED) often have severe physiological derangement and may require expedited intubation with limited opportunity for airway assessment. It is recognised that there is a higher incidence of difficult airway management scenarios in ED, many of which may be unpredicted. Thus, it is critical that

DATs be readily available. The specific configuration of DATs in individual EDs will largely be determined by local factors. However, ED DATs should be configured in a standardised manner consistent with other difficult airway trolleys in their institution.

There is increasing use of the videolaryngoscopes for first intubation attempts. The place of flexible bronchoscopy in ED is less well defined and access to equipment and skilled personnel may be via operating theatres or intensive care.

4.4 Ancillary equipment

Some equipment for management of difficult airways cannot be stored in DATs but should be readily available.

4.4.1 Flexible bronchoscopes

Flexible fibreoptic and/or video bronchoscopes should be readily available in all areas where advanced airway management is undertaken. They play an important role in tracheal intubation and extubation, evaluation of the upper and lower airways, and examination of the position of supraglottic airways, tracheal tubes and tracheostomy tubes. They are also useful tools for lower airway suctioning, foreign body retrieval and obtaining specimens.

In all clinical areas where airways are managed, the type (reusable or single use), size and number of flexible bronchoscopes will be determined by the case mix, case load and physical status of patients. Flexible bronchoscopy requires training and ongoing maintenance of practice. Thus, availability of both devices and clinicians skilled in their use needs to be considered.

A wide range of ancillary equipment is required to support the use of flexible bronchoscopes. This includes equipment for oxygenation and for topical application of local anaesthesia of the airway, lubricants, and bite blocks.

Ancillary equipment for flexible intubating bronchoscopes should include the following:

- Intubating catheter such as an Aintree Intubation Catheter™
- Spare battery or light source
- Mouth guard
- Bronchoscopy swivel connectors
- Anti-fog solution
- Local anaesthetic (sprays, ampoules, jelly, atomisers with applicators)
- Nasal vasoconstrictor
- Bite block and/or oral intubating airways
- Nasopharyngeal airways – internal diameter sizes 6, 7 and 8mm
- Selection of appropriate tracheal tubes
- Lubricant, gauze pads

4.4.2 High Flow Nasal Oxygen

High flow nasal oxygen (HFNO) allows a predictable titration of inspired oxygen concentration up to 95-100%. It increases apnoeic oxygenation time and improves oxygenation for awake intubation and shared airway procedures. However, it is not effective in cases of complete airway obstruction. Airway fire is a risk with use of laser and diathermy.

It is highly recommended that there is access to a HFNO delivery system in a convenient location close to any DAT.

See further below for appendices. This document is accompanied by a background paper (PG56BP) which provides more detailed information regarding the rationale and interpretation of the Guideline.

References

Please refer to PG56BP for list of references.

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Appendix 1

DAT drawer contents adult patients

Drawer		Contents
Essential devices	Laryngoscopy: Direct & Video	Laryngoscope handles: standard and short Spare batteries for handles Laryngoscope blades: Macintosh size 3 and 4 Videolaryngoscope and blades Tracheal tubes internal diameter (ID mm) 5.0, 6.0, 7.0, and 8.0 Microlaryngoscopy tubes internal diameter (ID mm) 5.0, and 6.0 Malleable blunt atraumatic stylet Lubrication gel Surgical tape Tracheal tube cloth tie Scissors Magill's forceps 10mL and 20mL syringes
	Supraglottic airway	First generation SADs sizes 3, 4, and 5 Second generation SADs sizes 3, 4, and 5 Orogastric tubes sizes 12Fr and 14Fr Lubrication gel 20mL syringe
	FaceMask	Facemasks for small adult, adult, large adult Neonatal facemask size 0 for patients with tracheostomy stomas Oropharyngeal airways: 7, 8, 9, 10, and 11 cm Nasopharyngeal airway: 6.0, 7.0, and 8.0 mm
	eFONA	Emergency cricothyroidotomy catheter set Tracheal tube internal diameter (ID mm) 6.0 Scalpel blade size 10 Tracheal tube introducer[1] with a Coudé tip of 35 degrees 14G straight cannula[2] with memory function and without safety valve 10mL 0.9% saline and 5mL syringe slip tip (non-luer -lock) Oxygen insufflation device,
	Monitoring	An immediate CO_2 detector, preferably a quantitative waveform capnograph or capnometer, to confirm ventilation by seeing a sustained exhaled CO_2 waveform of appropriate waveform morphology and amplitude
Non-Essential devices*		Intubating Laryngeal Mask Various types of laryngoscope blades: - straight (considered essential for paediatric DATs) - articulated tip - obstetric - guided or channelled devices Microlaryngoscopy tube ID 4.0mm Optical stylets

[1] Often referred to by the trade name Frova®
[2] An optimal cannula for this purpose is the BD Insyte™

Outside Containers	Contents
Vertical containers #1	11Fr and 14Fr airway exchange catheters Intubating catheters[3]
Vertical containers #2	Tracheal tube introducers /bougies

*Explanatory note – It is acknowledged that some operators are experienced with these devices. In facilities where operators have been trained and have an ongoing volume for any of these devices, it is reasonable to include them in DATs. Advice from the local Airway Lead should be sought prior to adding any non-essential devices to DATs.

[3] Often referred to by the trade name Aintree Intubating Catheter

Appendix 2

DAT drawer contents paediatric patients

The following list of paediatric equipment should supplement adult equipment which is still required for larger paediatric patients.

Drawer		Contents
Essential devices	Laryngoscopy: Direct & Video	Laryngoscopes: Macintosh blades sizes 1,2 and 3; Straight blades (e.g. Miller blades) sizes 0, 1 and 2 Laryngoscope handles of suitable illumination and compatible with blades. Spare batteries for handles Tracheal tube uncuffed 2.0, 2.5, 3.0, 3.5, 4.0 4.5, 5.0, 5.5 mm, and cuffed 3.0, 3.5, 4.0, 4.5, 5.0, 5.5. Microcuffed tube internal diameter (ID mm) 3.0, 4.0, 5.0 Stylet 2.0mm to fit tracheal tubes sizes 2.5-4.5, and stylet 4.0mm to fit tracheal tubes sizes 5.0-8.0 ET (ID) – Suction Catheter Size: 2.5mm – 5Fr, 3.0mm – 7Fr, 3.5 and 4.0mm – 8Fr, 4.5 and 5.0mm – 10Fr, 6.0mm – 10 and 12Fr, 7.0mm – 12Fr Paediatric Yankauer sucker and suction tubing Mapleson F circuit An immediate CO_2 detector - preferably a quantitative waveform capnograph or capnometer Infant, Child self-inflating resuscitation bag with PEEP valve and bacterial/viral filter Equipment checklist for re-stocking Logbook for checking procedures Lubrication gel Surgical tape Tracheal tube cloth tie Scissors Paediatric Magill's forceps 10mL syringe
	Supraglottic airway	SADs sizes 1, 1.5 ,2 ,2.5 ,3 ,4 20mL syringe
	FaceMask	Paediatric facemasks Nos. 0 to 4 Oropharyngeal airways: 000, 00, 0, 1, 2, 3, 4, 5 Nasopharyngeal airway: 3.0, 3.5, 4.0, 4.5, 5.0
	eFONA	Emergency cricothyroidotomy catheter set for infant and paediatric patient. Microcuffed tube internal diameter (ID mm) 3.0, 4.0, 5.0 Scalpel blade size 10, nurse scissors, towel forceps x3 Tracheal tube introducer[4] with a Coudé tip of 35 degrees 16G straight cannula[5] with memory function and without safety valve

[4] Often referred to by the trade name Frova®
[5] An optimal cannula for this purpose is the BD Insyte™

	10mL 0.9% saline and 5mL syringe slip tip (non-luer lock)lock Oxygen insufflation device,
Non-Essential devices*	
Outside Containers	**Contents**
Vertical containers #1	Airway exchange catheters and minimal internal diameter of corresponding tracheal tube: 7Fr: ≥ 2.5mm; 8Fr: ≥ 3.0mm; 11Fr: ≥ 4.0mm; 14Fr: ≥ 5.5mm; 19Fr: ≥ 7.0mm.
Vertical containers #2	Tracheal tube introducers /bougies sizes 5Fr and 10Fr

Appendix 3

Rapid deployment kit for use beyond critical care areas ("grab bag") – ADULT patients

A grab-bag is a portable emergency container that contains essential difficult airway management equipment for rapid deployment to clinical areas not readily serviced by the comprehensive DAT. Its contents should reflect the patient population of the healthcare facility.

Recommended contents for adult and adolescent patients include:

	Contents
Laryngoscopy: Direct & Video	Laryngoscope handles: standard, short; spare batteries Laryngoscope blades: Macintosh sizes 3 and 4 Portable videolaryngoscope with blades Tracheal tubes internal diameter (internal diameter in mm) 5.0, 6.0, 7.0 and, 8.0 Microlaryngoscopy tubes internal diameter (ID mm) ,5.0, and 6.0 Malleable stylet Tracheal tube introducer Lubrication gel Surgical tape Tracheal tube cloth tie Scissors Magill's forceps 10mL and 20mL syringes Yankauer sucker, suction catheter, suction tubing
Supraglottic airway	First and Second generation supraglottic airway devices (SAD) size 3, 4, and 5 Naso/Orogastric tube size 12 and 14 Fr Lubricating gel
FaceMask	Facemask small adult, adult, large adult Oropharyngeal airways: 7, 8, 9, 10, and 11cm Nasopharyngeal airway: 6.0, 7.0, and 8.0mm
eFONA	Emergency cricothyroidotomy catheter set Tracheal tube internal diameter (ID mm) 6.0, Scalpel blade size 10, Tracheal tube introducer[6] with a Coudé tip of 35 degrees 14G straight cannula[7] with memory function and without safety valve 10mL 0.9% saline and 5mL syringe slip tip (non-luer lock) Oxygen cricothyroidotomy insufflation device
Other equipment	Container for anaesthetic and resuscitation drugs (keep in refrigerator as required) with a range of syringes Self-inflating resuscitation bag with PEEP valve and bacterial/viral filter End-tidal CO2 preferably inline waveform analysis, or Colorimetric CO2 detector Equipment checklist for re-stocking Logbook for checking procedures

[6] Frova®
[7] BD Insyte

Appendix 4

Rapid deployment kit for use beyond critical care areas ("grab bag") – PAEDIATRIC patients

Drawer		Contents
Essential devices	Laryngoscopy: Direct & Video	Laryngoscopes: Macintosh blades sizes 1,2 and 3; Straight blades (e.g. Miller blades) sizes 0, 1 and 2 Laryngoscope handles of suitable illumination and compatible with blades. Tracheal tube uncuffed 2.0, 2.5, 3.0, 3.5, 4.0 4.5, 5.0, 5.5 mm, and cuffed 3.0, 3.5, 4.0, 4.5, 5.0, 5.5. Microcuffed tube internal diameter (ID mm) 3.0, 4.0, 5.0 Stylet 2.0mm to fit tracheal tubes sizes 2.5-4.5, and stylet 4.0mm to fit tracheal tubes sizes 5.0-8.0 Paediatric Magill's forceps ET (ID) – Suction Catheter Size: 2.5mm – 5Fr, 3.0mm – 7Fr, 3.5 and 4.0mm – 8Fr, 4.5 and 5.0mm – 10Fr, 6.0mm – 10 and 12Fr, 7.0mm – 12Fr Paediatric Yankauer sucker and suction tubing Mapleson F circuit End-tidal CO_2, prefrably inline waveform analysis or colorimetric CO_2 detector Infant, Child self-inflating resuscitation bag with PEEP valve and bacterial/viral filter Equipment checklist for re-stocking Logbook for checking procedures
	Supraglottic airway	SADs sizes 1, 1.5 ,2 ,2.5 ,3 ,4 20mL syringe
	FaceMask	Paediatric facemasks Nos. 0 to 4 Oropharyngeal airways: 000, 00, 0, 1, 2, 3, 4, 5 Nasopharyngeal airway: 3.0, 3.5, 4.0, 4.5, 5.0
	eFONA	Emergency cricothyroidotomy catheter set for infant and paediatric patient. Scalpel blade size 10, nurse scissors, towel forceps x3 Tracheal tube introducer[8] with a Coudé tip of 35 degrees 16G straight cannula[9] with memory function and without safety valve 10mL 0.9% saline and 5mL syringe slip tip (non-luer lock) Oxygen insufflation device,
Non-Essential devices*		

[8] Often referred to by the trade name Frova®
[9] An optimal cannula for this purpose is the BD Insyte™