Unanticipated difficult tracheal intubation- during routine induction of anaesthesia in an adult patient

Direct laryngoscopy → Any problems → Call for help

Plan A: Initial tracheal intubation plan

Direct laryngoscopy - check:
Neck flexion and head extension
Laryngoscope technique and vector
External laryngeal manipulation - by laryngoscopist
Vocal cords open and immobile
If poor view: Introducer (bougie) - seek clicks or hold-up
and/or Alternative laryngoscope

Not more than 4 attempts, maintaining:
(1) oxygenation with face mask and
(2) anaesthesia

succeed → Tracheal intubation

Verify tracheal intubation
(1) Visual, if possible
(2) Capnograph
(3) Oesophageal detector
"If in doubt, take it out"

failed intubation

Plan B: Secondary tracheal intubation plan

ILMA™ or LMA™
Not more than 2 insertions
Oxygenate and ventilate

succeed → Confirm: ventilation, oxygenation, anaesthesia, CVS stability and muscle relaxation - then fibreoptic tracheal intubation through IMLA™ or LMA™ - 1 attempt
If LMA™, consider long flexometallic,nasal RAE or microlaryngeal tube
Verify intubation and proceed with surgery

failed oxygenation
(e.g. SpO_2 < 90% with FiO_2 1.0)
via ILMA™ or LMA™

failed intubation via ILMA™ or LMA™

Plan C: Maintenance of oxygenation, ventilation, postponement of surgery and awakening

Revert to face mask
Oxygenate and ventilate
Reverse non-depolarising relaxant
1 or 2 person mask technique
(with oral ± nasal airway)

succeed → Postpone surgery
Awaken patient

failed ventilation and oxygenation

Plan D: Rescue techniques for "can't intubate, can't ventilate" situation

Difficult Airway Society Guidelines Flow-chart 2004 (use with DAS guidelines paper)