AIRWAY

Everybody gets high flow oxygen, full stop.

The following things cause you to reach for the tube:

- **reduced level of consciousness**
- **vomit in the oropharynx**
- **facial fractures, especially midface and mandible**
- **penetrating neck injury → SURGICAL AIRWAY**
- **the agitated patient for some reason refuses to lie supine- ? is their airway obstructing?**
- **IS THE LARYNX FRACTURED? There is a clinical triad:**
  - **Hoarseness**
  - **Subcutaneous emphysema**
  - **Palpable fracture**
  - **This makes you want to do a tracheostomy, or cricothyroidotomy**

OBJECTIVE SIGNS OF AIRWAY OBSTRUCTION:

- **AGITATION = hypoxia**
- **OBTUNDATION = hypercapnea**
- **CYANOSIS**
- **ACCESSORY MUSCLE USE**
- **STRIDOR or any sort of gurgling**
- **PARADOXICAL CHEST EXCURSION** (chest deflates with inspiration, abdomen distends)
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MANAGEMENT OF A THREATENED AIRWAY

- **The main thing is to keep the C-spine stable**
- **First get their motorcycle helmet off – with inline stabilization**
- **Get some sort of suction, suck away their upper airway mucus and blood or teeth**
- **Put them on high flow oxygen**
- **Do a chin lift/jaw thrust**
- **Get a Guedel airway in (oropharyngeal)**
- **Get your intubation stuff ready:**
  - **Sucker**
  - **Drugs, and someone to give them**
  - **Laryngoscope with working light**
  - **Someone to do inline stabilization**
  - **Someone to apply the cricoid pressure: Back, Up and Rightward Pressure (BURP)**

The cricoid pressure is NOT RELEASED until the cuff is inflated

A DEFINITIVE AIRWAY is

1) an endotracheal tube
2) with an inflated cuff
3) taped to the patients face.

Blind nasotracheal intubation is contraindicated in patients with apnoea.
Seeing as you use their breathing to guide the tube