

SECURING THE AIRWAY OF A CHILD WITH CRITICAL UPPER AIRWAY OBSTRUCTION (UAO)

OXYGENATION IS THE ABSOLUTE PRIORITY

Maintain with 100% oxygen via facemask +/- oro/ naso pharyngeal airway or laryngeal mask airway.

Keep stomach decompressed with large orogastric tube.

Move the child to theatre if it is safe to do so

1. GAS induction

CPAP HELPS

Gas induction may be slow or impossible in critical UAO. Increased work of breathing may worsen UAO.

IV induction may be appropriate (necessary outside of theatre)

2. Consider MUSCLE RELAXANT

Especially if the patient becomes apnoeic OR outside of the theatre environment

Muscle relaxant may make mask ventilation and intubation easier.

3. INTUBATION by ANAESTHETIST

Repeat attempts only if $SpO_2 > 90\%$
MAXIMUM OF FOUR

Optimise position/ change laryngoscope blade/ cricoid pressure/ secondary intubation technique.

FAIL

4. INTUBATION by ENT

FAIL

Lindholm laryngoscope with Havers light clip and Hopkins rod – see overleaf.

OR Bonfils scope (may be operated by anaesthetist).

5. Emergency TRACHEOSTOMY

OR consider cricothyroidotomy if ENT unavailable

Tracheostomy size chart overleaf.



	Preterm - 1mnth	1-6 mnths	6-18 mnths	18 mnth - 3 yrs	3-6 yrs	6-9 yrs	9-12 yrs
ET Tube size for normal airway	2.5 or 3.0	3.5	4.0	4.5	5.0	6.0	7.0
	A smaller ET tube than expected may be needed. Consider a cuffed tube so any leak can be easily minimised						
Laryngoscope	Small Lindholm	Small Lindholm	Small Lindholm	Medium Lindholm	Medium Lindholm	Medium Lindholm	Young Adult Lindholm or Adult
Hopkins Rod	2.1mm short	2.1mm short	2.1mm short	3mm long	3mm long	3mm long	3mm long
Bivona cuffed Tracheostomy	2.5 or 3.0 neo length	3.5 neo length	4.0 paed length	4.5 paed length	5.0 paed length	5.5 paed length	6.0 paed length