TRACHEOSTOMY AND OTHER EMERGENCY AIRWA Y MEASURES

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This procedure relieves airway obstruction or protects the airway by fashioning a direct entrance into the trachea through the skin of the neck. Tracheostomy may be carried out as an emergency for acute airway obstruction when the larynx cannot be intubated, but it is not always an easy procedure, particularly in an obese patient. An easier alternative for the inexperienced is insertion of a large intravenous cannula or a small tube into the cricothyroid membrane, which lies in the midline immediately below the thyroid cartilage. The time to do a tracheostomy is when you first think it may be necessary . If time allows, the following should be undertaken: /uni25CF inspection and palpation of the neck to assess the laryngo tracheal anatomy in the individual patient; /uni25CF indirect or direct laryngoscopy; /uni25CF assessment of pulmonary function by auscultation. Whenever possible, the procedure should be adequately explained to the patient beforehand, with particular emphasis on the inability to speak immediately following the operation. Ample reassurance is required that they will not have ‘lost’ their voice permanently . The indications for tracheostomy are shown in Summary box 52.10 . Within the theatre or intensive care setting, the ‘can’t intu bate, can’t oxygenate’ situation occurs after attempts to secure the airway by a facemask, a supraglottic airway device and an endotracheal tube have failed. Only a narrow window exists avoid profound hypoxia and its consequences and local proto cols should be agreed upon to manage these situations before hand using appropriate emergency front of neck access options (cricothyroidotomy or tracheostomy). TRACHEOSTOMY AND OTHER EMERGENCY AIRWA Y MEASURES

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