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**RESEARCH ARTICLE**

# Management of Unanticipated Failed Intubation using Flexible Fiberoptic Bronchoscope in an Emergency Situation; Modification of DAS difficult intubation algorithm:

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## *Abstract*

We present a case of unanticipated failed intubation posted for a routine maxillofacial surgical procedure that was managed successfully by fiberoptic aided intubation after the patient was prepared for routine intubation using direct larngoscopy, but the later was not possible.



## INTRODUCTION

Failed intubation continues to remain a challenge for Anesthetist. The favourable outcome, apart from anesthetist's knowledge and skill, depends upon how much one is prepared to meet this challenge. The situation of loss of airway can be a disaster if approach is not timely and rational.

Here we present a case of failed intubation using direct laryngoscope (DL), which was successfully managed by fiberoptic aided (FOA) intubation in an emergency situation.

One male patient aged about 65 years, with patient ID 123604, was posted for right infraorbital neurectomy for trigeminal neuralgia on morning of 2nd March 2012, in SKIMS MC Srinagar in the Department of Maxillofacial Surgery. There was nothing significant in patient's history, and physical examination with routine investigation was within normal limits. Only finding noticed and reported by the resident doctor during pre anesthetic evaluation of the patient was a Mallampati score of II. Following induction, the patient received rocronium 0.6 mg/Kg to facilitate tracheal intubation. As intubation using DL was attempted, a Corkmac Lehane (CL) Score of IV was noticed and intubation using DL was impossible. As the oxygenation of patient was restoring, a flexible fiberoptic brochoscopy with a mounted cuffed endotracheal tube was kept ready.FOA intubation was successful after effective suction and carefully cleaning the illuminating tip of the bronchoscope. After visualizing the tracheal rings and carina, the ETT was carefully slided into the trachea. The surgery was successfully accomplished and the patient recovered normally.

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**Discussion**

The fiberoptic bronchoscope, presently, has to be a ubiquitous tool in anesthesia. The technique FOA intubation was first performed using a choledoscope in a patient with Still's disease [1]. By the late 1980 it was recognised that the use of flexible fiberoptic bronchoscope represents such a significant advancement in the management of the patient with difficult airway that experts stated that no anaesthesiologist could afford not to be facile with this technique [2]. It is now generally accepted that for a variety of clinical situations, the fiberoptic bronchoscope is a critical tool in the armamentarium of the anaesthesiologist dealing with patient, who is, or appears to be, difficult to intubate. The fiberoptic bronchoscope has proven to be most versatile tool available in this regard [3].

Though awake intubation using flexible fiberoptic bronchoscope remains golden standard for anticipated or proved difficult intubation, its use in unanticipated difficult airway with an unconscious and paralysed patient may save precious time and life. Compared to awake intubation, FOA intubation in an unconscious and paralysed patient has to be achieved quickly, as there is obivious time limiting factor. So, we are of the opinion that DAS difficult intubation algorithm can be modified to save time, Mand at times, life. Switching over to DAS plan B from plan A in wake of a dificult airway, we can directly go to fiberoptic aided intubation before plan B is excuted to save time after patients oxgenation is reasonably optimized ,without using LMA.The successful outcome in such a situation will depend upon the anesthesiologist's familiarity and experience with FOA intubation.

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