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POLICY UNDER REVIEW

Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Document Title	Failed Intubation in Obstetric Patients Clinical Guideline V2.0		
This document replaces (exact title of previous version):	Failed intubation in obstetric patients V1.3		
Date Issued/Approved:	6th September 2018		
Date Valid From:	10th October 2018		
Date Valid To:	April 2022		
Directorate / Department responsible (author/owner):	Dr Sam Banks Obstetric and Gynaecology Directorate		
Contact details:	01872 253132		
Brief summary of contents	To give guidance to obstetric anaesthetists in the management of a failed intubation in an obstetric patient		
Suggested Keywords:	Failed, intubation, general, anaesthetic, emergency, obstetric, GA		
Target Audience	RCHT	CFT	KCCG
	✓		
Executive Director responsible for Policy:	Medical Director		
Approval route for consultation and ratification:	Obstetric Consultant Anaesthetists Meeting Maternity Guidelines Group Obs and Gynae Directorate		
General Manager confirming approval processes	Mary Baulch		
Name of Governance Lead confirming approval by specialty and care group management meetings	Caroline Amukusana		
Links to key external standards	None.		

UNDER REVIEW

Related Documents:	• Management of the difficult and failed airway in obstetric anaesthesia – review article. Journal of Anaesthesia. 2008; 22: 38-48. • Hawthorne, L et al. Failed intubation revisited: 17-yr experience in a teaching maternity unit. British Journal of Anaesthesia. 1996; 76: 680-684 • Awan, R et al. Case Report and Review. Use of a ProSeal™ laryngeal mask airway for airway maintenance during emergency Caesarean section after failed tracheal intubation .2004;92:144-146. • Obstetric Anaesthetist Association website – www.oaa-anaes.ac.uk • Royal College of Anaesthetists website – www.rcoa.ac.uk • PD Barnardo, JG Jenkins. Failed tracheal intubation in obstetrics: a 6-year review in a UK region. Anaesthesia 2000;55:685-694 • Anon. 7th Annual Report of the Confidential Enquiry into Maternal Deaths in United Kingdom:1985-87, 1988-90, 1991,93.2003-05.London HMSO. • M C Mushambi et al. OAA and DAS guidelines for the management of difficult and failed tracheal intubation in obstetrics: Anaesthesia 2015, 70,1286-1306 4th National Audit Project (NAP4): Major complications of airway management in the UK. Report and Findings March 2011			
Training Need Identified?	Training on-going though training logbooks.			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Clinical / Midwifery and Obstetrics			

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Failed Intubation in Obstetric Patients Clinical Guideline

V2.0

September 2018

UNDER REVIEW

1. Aim/Purpose of this Guideline

To give guidance to obstetric anaesthetists in the preparation for general anaesthesia and management of a failed intubation in an obstetric patient.

2. The Guidance

2.1. Definition

A failed intubation in obstetrics is one that is not accomplished following a rapid sequence induction of anaesthesia

2.2. Incidence

The incidence of failed intubation has been shown to be as high as 1 in 250 in obstetric patients.

2.3. Background

Failed tracheal intubation is an important factor contributing to maternal morbidity and mortality and can delay the delivery of the compromised foetus.

Anaesthetists cannot always predict difficult intubations, but the following can minimise the risk:

- Adequate assessment of the airway pre-operatively
- Having adjunctive airway equipment available
- A plan as to whether to wake the patient or proceed with surgery in the event of failed intubation **(New 2018)**
- Having a robust plan for the management of a failed intubation (Failed Intubation Drill) In 2015 the Difficult airway society (DAS) in conjunction with the Obstetric Anaesthetists Association (OAA) produced new guidelines for the management of difficult and failed intubation in obstetric patients. These are the first national obstetric-specific failed intubation guidelines in the UK **(New 2018).**

2.4 (New 2018) DAS and OAA guidelines for difficult and failed intubation consists of 4 algorithms and 2 tables (see appendices)

- Master algorithm gives an overview (Appendix 3)
- Algorithm 1 gives a framework on how to optimise a safe general anaesthetic (GA) technique (Appendix 4)
- Table 1 gives a structure for deciding whether to wake the patient or proceed should intubation fail (Appendix 5)
- Algorithm 2 summarises the management of failed tracheal intubation (appendix 6)
- Algorithm 3 covers 'can't intubate, can't oxygenate' (Appendix 7)
- Table 2 gives management after failed intubation (Appendix 8)

2.5 (New 2018) **Algorithm 1**

Importance of preparation and planning

2.5.1 Pre-theatre planning

- An anaesthetic risk assessment should be completed at booking by the midwife and should any single risk factor be identified a referral

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to the obstetric anaesthetic clinic should be made.
Women predicted to have airway difficulties should be referred antenatally for specific anaesthetic plan **(New 2018)**

UNDER REVIEW

- Airway assessment

An anaesthetic assessment should be made and should include airway assessment for bag mask ventilation, intubation, and front-of-neck access. Oral piercings should be removed **(New 2018)**

- Fasting status and antacid prophylaxis **(New 2018)**

Refer to RCHT fasting guidelines for general anaesthesia
H2 receptor antagonists should be prescribed the night before surgery and the morning of surgery for elective Caesarean Section.
High risk women in labour should not eat but may have clear fluids and be prescribed regular H2 Receptor antagonists every 6h for the duration of their labour.
If no H2 receptor antagonist has been administered it should be given iv prior to induction
Sodium Citrate should be administered prior to induction (New 2018)

2.5.2 Plan with team (New 2018)

- Category of Caesarean section
- WHO checklist. May be modified for category 1 Caesarean section
- Check standardised difficult airway equipment trolley is available
- Identify senior help and call if necessary
- Whether to continue or wake patient if difficult intubation occurs.

Refer to Table 1 (Appendix 3)

- Has intrauterine fetal resuscitation been undertaken?

Table 1 – to wake patient or proceed with surgery? (Appendix 3) **(New 2018)**

- This should be discussed with the obstetric team prior to induction and factors listed in Table 1 should be considered
- The anaesthetist should consider whether (s)he would be happy to proceed with surgery with a Supraglottic Airway Device (SAD)
- Overriding reason to proceed with GA is maternal compromise not responsive to resuscitation and acute foetal compromise secondary to an irreversible cause
- Firm Indications to wake the mother are supraglottic swelling and continued airway obstruction in the presence of optimised SAD management.

2.5.3 Rapid sequence induction (New 2018)

Optimise patient position

- Left lateral tilt
- Head up 20-30 degrees.
- Ramped position in morbidly obese parturients

Pre-oxygenation

- To fractional ET O2>0.9
- Consider high-flow humidified Oxygen (apnoeic oxygenation) using THRIVE

Cricoid pressure

- 10N increasing to 30N as patient loses consciousness

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- Reduce this to 20N if patient head-up

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- Low threshold to release cricoid pressure if intubation or mask ventilation prove difficult.
- Be prepared to reapply cricoid pressure, suction and introduce head-down tilt if regurgitation should occur

Drug administration

- Propofol vs Thiopentone. Use drug most familiar to your practise. Advantage of Propofol is familiarity and suppression of laryngeal reflexes for SAD. Ensure adequate dose
- Suxamethonium vs Rocuronium. Suxamethonium increases oxygen consumption and may cause earlier desaturation. **DO NOT GIVE A 2ND DOSE of SUXAMETHONIUM** no matter how tempting
- Rocuronium/Sugamadex combination is expensive

Consider facemask ventilation

- Low inflation breaths at low pressures (<20cmH2O) after induction.

First intubation attempt

- Consider videolaryngoscope as first line device in morbidly obese, potential difficult airway and in second intubation attempt if mac blade was used initially.
- If first attempt fails, consider repositioning, releasing cricoid or manipulating assistants hand, different laryngoscope, bougie. Avoid airway trauma.

Second intubation attempt

- By most experienced anaesthetist present
- Consider manoeuvres above
- Consider further dose of induction agent to prevent awareness

Verify tracheal intubation

- Capnography
- Visualising tube between cords
- Auscultation
- Fibre optic visualisation of tracheal rings and carina

2.5.4 Important points

The prime aim of the failed intubation drill is to keep the mother oxygenated. Regional anaesthesia is preferred to a general anaesthetic for delivery of the distressed neonate by caesarean section unless contraindicated.
Maternal welfare always takes precedence over fetal compromise.
Morbidly obese women should not be anaesthetised by trainees without senior consultation.

2.6 Algorithm 2 Obstetric failed tracheal intubation (Appendix 4) (New 2018)

- If second attempt is unsuccessful declare a failed intubation to the team
- Request more experienced help
- MAINTAIN OXYGENATION via facemask or SAD

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- Prevent aspiration and awareness
- Consider oropharyngeal airway, 2-person technique and release of cricoid pressure if facemask ventilation is difficult

UNDER REVIEW

- If facemask ventilation difficult and decision has been made to proceed with surgery, insert 2nd generation SAD with gastric drain (May need to release cricoid pressure)
- If first SAD does not provide effective airway, insert alternative size or device
- Maximum of 2 insertions

2.7 Algorithm 3 "Can't intubate, can't oxygenate" (New 2018)

- Ensure all modifiable features have been treated, eg laryngeal spasm, poor chest wall compliance. A further dose of muscle relaxant may improve the situation.
- Call specialist help, ie ENT surgeon or intensivist.
- Attempt front of neck procedure with blade and endo tracheal tube.
- In the event of failure to restore oxygenation- cardiac arrest protocol should be followed including Caesarean Delivery

2.7.1 If adequate oxygenation has been maintained a decision as to wake the patient or proceed should be made Table 2 (Appendix 3) **(New 2018)**

2.7.2 Decision to wake **(New 2018)**

- Decision to wake patient may be based on presence of partially compromised airway with suboptimal airway control, airway oedema, stridor, and airway bleeding.
- If decision to wake, maintain oxygenation and avoid regurgitation, vomiting and awareness.
- Beware laryngeal spasm on arousal.
- Reverse muscle relaxant
- Review urgency of delivery of fetus with obstetrician on awakening – consider regional technique, awake intubation, or elective tracheostomy.
- Inform neonatologist.

2.7.3 Decision to proceed. Key issues to consider are:

- Airway device and ventilation strategy
- Maintenance of anaesthesia
- Use of cricoid pressure
- Drainage of gastric contents
- Plans to perform delayed tracheal intubation
- Surgery should be performed by most experienced surgeon present
- Constant evaluation of airway patency, ventilation and oxygenation throughout case

May have to accept suboptimal conditions until after delivery when pulmonary compliance may improve.

2.8 Extubation of the trachea (New 2018)

- 30% of adverse events occur at the end of anaesthesia (4th NAP project)
- Key issues are planning and preparation including options for re-intubation

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- Perform awake extubation unless transfer to the intensive care unit for controlled ventilation and extubation is indicated

UNDER REVIEW

2.9 Debriefing and follow-up(New 2018)

- Successful debriefing is achieved by identifying aspects of good performance, areas of improvement and suggestions of what could have been done differently in future
- Perform follow-up visit. If necessary arrange an ENT review if evidence of airway trauma
- Ask specifically about awareness
- Full documentation should be made about ease of bag mask ventilation, grade of laryngoscopy, airway equipment or adjuncts use.
- For a difficult/failed intubation a letter for the patient and for her GP should be sent.

2.10. Training and awareness

Annual training to be carried out by all the anaesthetists that work on the obstetric unit.

2.11. Documentation

There should be clear documentation in the maternal records as to the events and treatment administered.

3. Monitoring compliance and effectiveness

Element to be monitored	All cases of failed intubation.
Lead	Anaesthetic Risk Management Lead.
Tool	All cases of failed intubation will be reported via the trusts electronic reporting system (Datix) and reviewed at the clinical incident review meeting.
Frequency	Every case
Reporting arrangements	Individual feedback for each case. Any training needs identified to be reported to the anaesthetic training lead consultant.
Acting on recommendations and Lead(s)	Any action plans will be monitored though the Maternity Risk Management Forum.
Change in practice and lessons to be shared	One to one individual feedback. Training needs addressed through Consultant Anesthetic Training Lead.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

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Appendix 1. Governance Information

Document Title	Failed Intubation In Obstetric Patients Clinical Guideline V2.0
Date Issued/Approved:	6th September 2018
Date Valid From:	10th October 2018
Date Valid To:	10th October 2021
Directorate / Department responsible (author/owner):	Dr Sam Banks Obstetric and Gynaecology Directorate
Contact details:	01872 253132
Brief summary of contents	To give guidance to obstetric anaesthetists in the management of a failed intubation in an obstetric patient
Suggested Keywords:	Failed, intubation, general, anaesthetic, emergency, obstetric, GA
Target Audience	RCHT ✓ | CFT | KCCG
Executive Director responsible for Policy:	Medical Director
Date revised:	August 2018
This document replaces (exact title of previous version):	Failed intubation in obstetric patients v1.3
Approval route (names of committees)/consultation:	Obstetric Consultant Anaesthetists Meeting Maternity Guidelines Group Obs and Gynae Directorate Policy review group
Divisional Manager confirming approval processes	Tunde Adewopo
Name and Post Title of additional signatories	Not required
Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings	{Original Copy Signed} Name: Caroline Amukusana
Signature of Executive Director giving approval	{Original Copy Signed}
Publication Location (refer to Policy	Internet & Intranet ✓ | Intranet Only

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on Policies – Approvals and Ratification):				
Document Library Folder/Sub Folder	Clinical Midwifery/Obstetrics			
Links to key external standards	None			
Related Documents:	• Management of the difficult and failed airway in obstetric anaesthesia – review article. Journal of Anaesthesia. 2008; 22: 38-48. • Hawthorne, L et al. Failed intubation revisited: 17-yr experience in a teaching maternity unit. British Journal of Anaesthesia. 1996; 76: 680-684 • Awan, R et al. Case Report and Review. Use of a ProSeal™ laryngeal mask airway for airway maintenance during emergency Caesarean section after failed tracheal intubation .2004;92:144-146. • Obstetric Anaesthetist Association website – www.oaa-anaes.ac.uk • Royal College of Anaesthetists website – www.rcoa.ac.uk • PD Barnardo, JG Jenkins. Failed tracheal intubation in obstetrics: a 6-year review in a UK region. Anaesthesia 2000;55:685-694 • Anon. 7th Annual Report of the Confidential Enquiry into Maternal Deaths in United Kingdom:1985-87, 1988-90, 1991,93.2003-05.London HMSO. • M C Mushambi et al. OAA and DAS guidelines for the management of difficult and failed tracheal intubation in obstetrics: Anaesthesia 2015, 70,1286-1306 • 4th National Audit Project (NAP4): Major complications of airway management in the UK. Report and Findings March 2011				
Training Need Identified?	Training on-going though training log books.			

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Version Control Table

Date	Version	Summary of Changes	Changes Made by *(Name and Job Title)*
January 2006	V1.0	Initial Issue.	Dr Bill Harvey Consultant Anaesthetist.
December 2009	V1.1	Addition of a flow chart.	Dr Catherine Ralph Consultant Anaesthetist.
February 2012	V1.2	Addition of compliance monitoring table.	Dr Catherine Ralph Consultant Anaesthetist.
17th July 2015	V1.3	Minor change: Spontaneously Breathing following General Anaesthetic: Proceed with caution	Dr Sam Banks Consultant Anaesthetist
6th September 2018	V2.0	Major change to include DAS/OAA guidelines	Dr Sam Banks Consultant Anaesthetist

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Appendix 2. Initial Equality Impact Assessment Form

This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.

<table>
<tr><td colspan="6">Name of Name of the strategy / policy /proposal / service function to be assessed
Failed Intubation In Obstetric Patients Clinical Guideline V2.0</td></tr>
<tr><td colspan="3">Directorate and service area:
Obstetrics & Gynae</td><td colspan="3">Is this a new or existing Policy?
Existing</td></tr>
<tr><td colspan="3">Name of individual completing assessment:
Sam Banks</td><td colspan="3">Telephone:
01872 252879</td></tr>
<tr><td>1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">To give guidance to obstetric anaesthetists in the management of a failed intubation in an obstetric patient.</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="5">To appropriately manage a failed intubation incident in the obstetric patient.</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="5">Safety of the woman.</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="5">As per Compliance Monitoring Tool.</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">Obstetric patients undergoing general anaesthesia.</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups
Obstetric Consultant Anaesthetists Meeting
Maternity Guidelines Group
Obs and Gynae Directorate
Policy review group</td></tr>
<tr><td>What was the outcome of the consultation?</td><td colspan="5">Guideline agreed</td></tr>
</table>

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7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		X		All pregnant women
Sex (male, female, trans-gender / gender reassignment)		X		All pregnant women
Race / Ethnic communities /groups		X		All pregnant women
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		X		All pregnant women
Religion / other beliefs		X		All pregnant women
Marriage and Civil partnership		X		All pregnant women
Pregnancy and maternity		X		All pregnant women
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		X		All pregnant women

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this <u>excludes</u> any *policies* which have been identified as not requiring consultation. **or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No** X	

9. If you are **not** recommending a Full Impact assessment please explain why.

No areas indicated

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Signature of policy developer / lead manager / director Dr Sam Banks		Date of completion and submission 6th September 2018
Names and signatures of members carrying out the Screening Assessment	1. Sam Banks 2. Human Rights, Equality & Inclusion Lead	

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust's web site.

Signed Sarah-

Jane Pedler Date

6th September

2018

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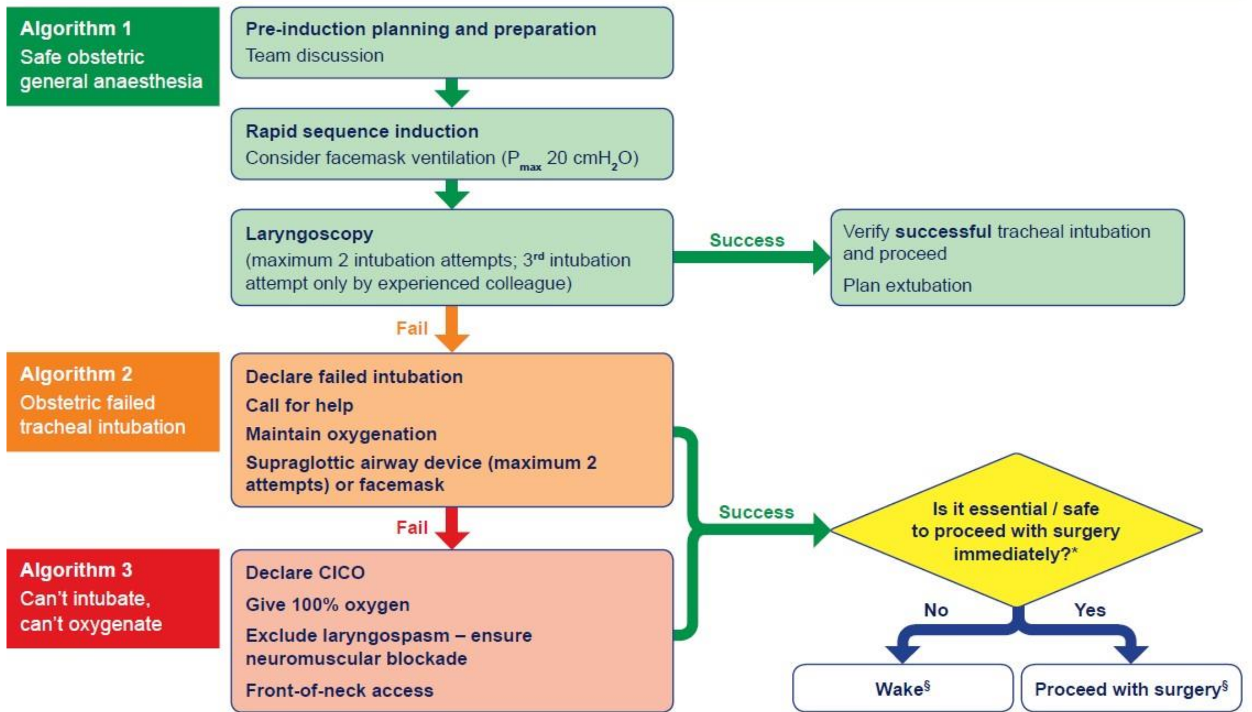
Appendix 3



*See Table 1, §See Table 2

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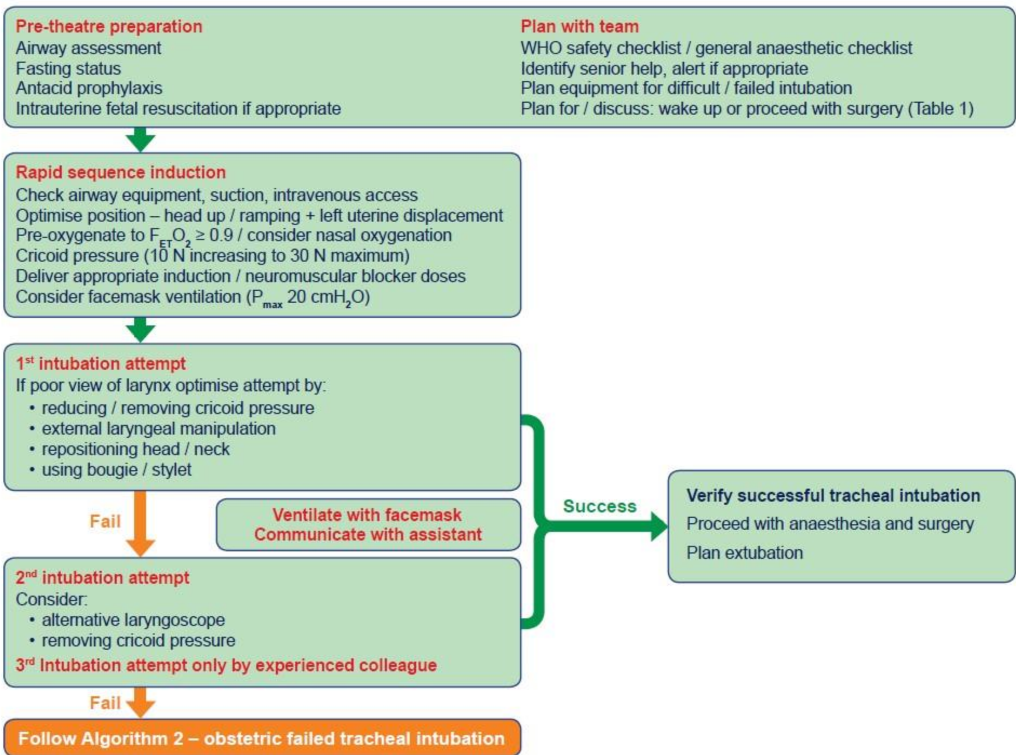

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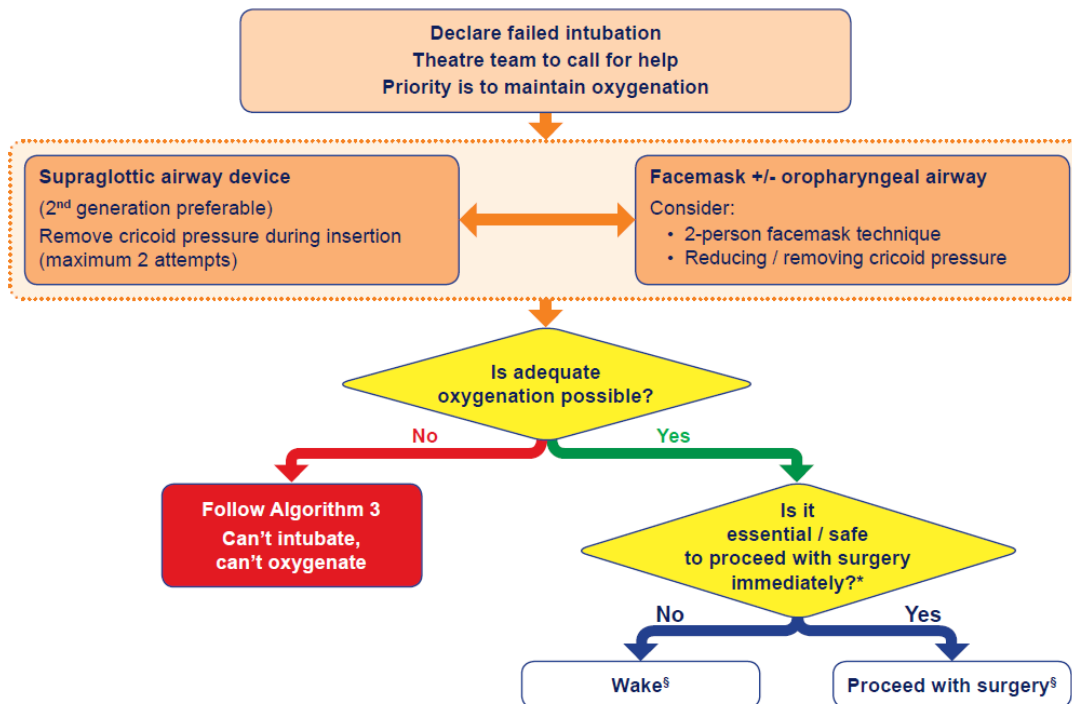

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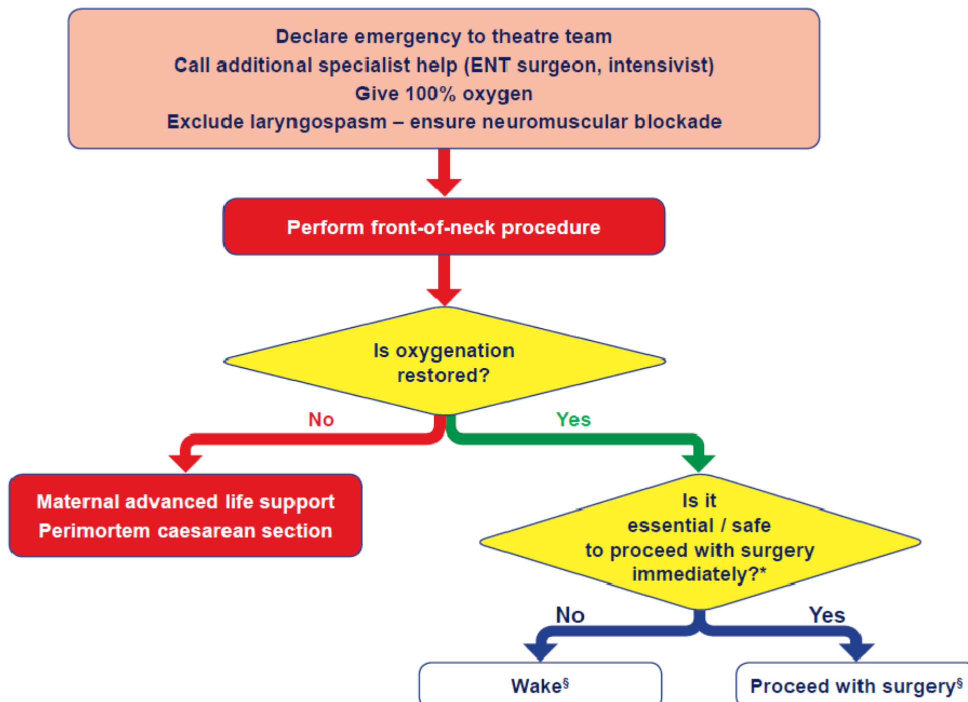

*See Table 1, §See Table 2

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Table 1 – proceed with surgery?

	Factors to consider	WAKE	⟵	⟶	PROCEED
Before induction	**Maternal condition**	• No compromise	• Mild acute compromise	• Haemorrhage responsive to resuscitation	• Hypovolaemia requiring corrective surgery • Critical cardiac or respiratory compromise, cardiac arrest
Before induction	**Fetal condition**	• No compromise	• Compromise corrected with intrauterine resuscitation, pH < 7.2 but > 7.15	• Continuing fetal heart rate abnormality despite intrauterine resuscitation, pH < 7.15	• Sustained bradycardia • Fetal haemorrhage • Suspected uterine rupture
Before induction	**Anaesthetist**	• Novice	• Junior trainee	• Senior trainee	• Consultant / specialist
Before induction	**Obesity**	• Supermorbid	• Morbid	• Obese	• Normal
Before induction	**Surgical factors**	• Complex surgery or major haemorrhage anticipated	• Multiple uterine scars • Some surgical difficulties expected	• Single uterine scar	• No risk factors
Before induction	**Aspiration risk**	• Recent food	• No recent food • In labour • Opioids given • Antacids not given	• No recent food • In labour • Opioids not given • Antacids given	• Fasted • Not in labour • Antacids given
Before induction	**Alternative anaesthesia** • **regional** • **securing airway awake**	• No anticipated difficulty	• Predicted difficulty	• Relatively contraindicated	• Absolutely contraindicated or has failed • Surgery started
After failed intubation	**Airway device / ventilation**	• Difficult facemask ventilation • Front-of-neck	• Adequate facemask ventilation	• First generation supraglottic airway device	• Second generation supraglottic airway device
After failed intubation	**Airway hazards**	• Laryngeal oedema • Stridor	• Bleeding • Trauma	• Secretions	• None evident

Criteria to be used in the decision to wake or proceed following failed tracheal intubation. In any individual patient, some factors may suggest waking and others proceeding. The final decision will depend on the anaesthetist's clinical judgement.

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Table 2 – management after failed tracheal intubation

Wake

- Maintain oxygenation
- Maintain cricoid pressure if not impeding ventilation
- Either maintain head-up position or turn left lateral recumbent
- If rocuronium used, reverse with sugammadex
- Assess neuromuscular blockade and manage awareness if paralysis is prolonged
- Anticipate laryngospasm / can't intubate, can't oxygenate

After waking

- Review urgency of surgery with obstetric team
- Intrauterine fetal resuscitation as appropriate
- For repeat anaesthesia, manage with two anaesthetists
- Anaesthetic options:
  - Regional anaesthesia preferably inserted in lateral position
  - Secure airway awake before repeat general anaesthesia

Proceed with surgery

- Maintain anaesthesia
- Maintain ventilation - consider merits of:
  - controlled or spontaneous ventilation
  - paralysis with rocuronium if sugammadex available
- Anticipate laryngospasm / can't intubate, can't oxygenate
- Minimise aspiration risk:
  - maintain cricoid pressure until delivery (if not impeding ventilation)
  - after delivery maintain vigilance and reapply cricoid pressure if signs of regurgitation
  - empty stomach with gastric drain tube if using second-generation supraglottic airway device
  - minimise fundal pressure
  - administer H_2 receptor blocker i.v. if not already given
- Senior obstetrician to operate
- Inform neonatal team about failed intubation
- Consider total intravenous anaesthesia

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All algorithms and tables reproduced from Mushambi MC, Kinsella SM, Popat M, Swales H, Ramaswarmy KK, Winton AL, Quinn AC. Obstetric Anaesthetists' Association and Difficult Airway Society guidelines for the management of difficult and failed tracheal intubation in obstetrics. Anaesthesia 2015; 70:1286-1306, with permission from Obstetric Anaesthetists'

Association/Difficult Airway Society.

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