

# Recommendations for Airway Management in a Patient with Suspected Coronavirus (2019-nCoV) Infection

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## General

**Your** personal protection is **the** priority. Personal protective equipment (PPE) should be available for all providers to ensure droplet/contact isolation precautions can be achieved. Providers and organizations should review protocols for donning and doffing PPE. Careful attention is required to avoid self-contamination.

### Patients with confirmed or suspected 2019-nCoV infected cases:

- Should **NOT** be brought to holding or PACU areas
- Should be managed in a **designated OR**, with signs posted on the doors to minimize staff exposure.
- Should be **recovered in the OR** or **transferred to ICU** into a negative pressure room. Ensure a high quality HMEF (Heat and Moisture Exchanging Filter) rated to remove at least 99.97% of airborne particles 0.3 microns or greater is placed between the ETT and reservoir bag during transfers to avoid contaminating the atmosphere.

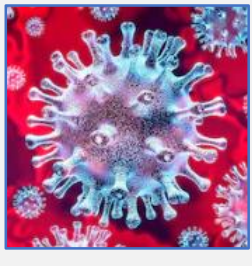
### Plan ahead:

- For time to allow all staff to apply PPE and barrier precautions
- Consider intubation early to avoid the risk of a crash intubation when PPE cannot be applied safely.

## During Airway Manipulation

### Apply:

- Disposable mask, goggles, footwear, gown and gloves. Consider adopting the **double glove** technique.
- Standard ASA monitoring should be applied before induction of anesthesia.
- N95 mask at a minimum should be utilized. PAPR devices may offer superior protection when manipulating an airway of an infected patient.



### Assign:

- Designate the most experienced anesthesia professionals available to perform intubation, if possible. Avoid trainee intubation for sick patients.



### Avoid:

- Awake fiberoptic intubation, unless specifically indicated. Atomized local anesthetic can aerosolize the virus.



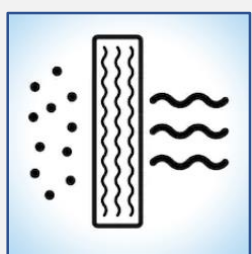
### Prepare to:

- Preoxygenate for 5 minutes with 100% FiO<sub>2</sub>
- Perform a rapid sequence induction (RSI) to avoid manual ventilation of patient's lungs and potential aerosolization of virus from airways.
- Consider using a video-laryngoscope.



### RSI:

- Depending on the clinical condition, the RSI may need to be modified. If manual ventilation is required, apply small tidal volumes.



### Use:

- Ensure there is a high quality HMEF (Heat and Moisture Exchanging Filter) rated to remove at least 99.97% of airborne particles 0.3 microns or greater placed in between the facemask and breathing circuit or between facemask and reservoir bag.

### Dispose:

- Re-sheath the laryngoscope immediately post intubation (**double glove technique**)
- Seal all used airway equipment in a double zip-locked plastic bag. It must then be removed for decontamination and disinfection.



### Remember:

- After removing protective equipment, avoid touching your hair or face before washing hands.