AIRWAY & RSI

Rapid Sequence Intubation · prepare for the difficult airway

OXYGENATE
not just intubate

THE 7 Ps

sequence of preparation

1. **Prepare**
2. **Preoxygenate**
3. **Optimise**
4. **Paralyse + induce**
5. **Position**
6. **Prove (capnography)**
7. **Post-care**

DRUGS

adult IV; reduce in shock / frailty

INDUCTION

Ketamine 1-2 mg/kg (1 if shocked)
agent of choice in shock; bronchodilator

Etomidate 0.3 mg/kg (0.15 shock)
cardiostable; single-dose adrenal suppression

Propofol 1.5-2.5 mg/kg
avoid / reduce in shock (vasodilation)

PARALYTICS

Rocuronium 1.0-1.2 mg/kg
onset 45-60 s, lasts 45-70 min; reverse sugammadex 16 mg/kg

Suxamethonium 1.0-1.5 mg/kg
onset 45 s, lasts 6-10 min

Sux contraindicated: hyperkalaemia, burns > 24 h, denervation / crush, myopathy, malignant hyperthermia - use rocuronium.

PREDICT DIFFICULTY

LEMON

- **L** Look externally (beard, trauma, obesity, small mandible)
- **E** Evaluate 3-3-2 (mouth, chin-hyoid, hyoid-thyroid)
- **M** Mallampati 3-4
- **O** Obstruction / Obesity
- **N** Neck mobility restricted

PREOXYGENATE

- **3 minutes -** tidal breathing (or 8 vital-capacity breaths) on high-flow O_2
- **Apnoeic O_2 -** nasal cannula 15 L/min left ON throughout laryngoscopy
- **Shunt physiology -** use CPAP / NIV to preoxygenate
- **Abort & re-oxygenate -** if SpO_2 falls to 90-93%
- **MACOCHA -** validated ICU difficulty score (≥ 3 predicts difficulty)

FAILED AIRWAY · PLAN A to D

oxygenation always beats intubation

A Intubate

max 3 attempts (+1 senior); optimise: reposition, bougie, videolaryngoscopy

B Supraglottic

2nd-gen SAD, max 3; stop and think

C Facemask

two-person, adjuncts, full paralysis

D Front-of-neck

CICO: scalpel-bougie-tube cricothyroidotomy - declare early

POST-INTUBATION CARE

CONFIRM

Waveform capnography (mandatory), bilateral air entry, CXR (tip 3-5 cm above carina). Note depth at lips.

SETTINGS

Analgesia first, then sedation (avoid awareness). Lung-protective VT 6-8 mL/kg PBW, plateau < 30; titrate PEEP / FiO_2.

STABILISE

OG tube, head-up 30-45 degrees. Treat and prevent post-intubation hypotension and hypoxia; recheck ABG.

PHYSIOLOGICALLY DIFFICULT AIRWAY (resuscitate first): hypotension - fluid bolus + push-dose pressor (phenylephrine 50-100 mcg or adrenaline 10-20 mcg IV) or start noradrenaline; hypoxia - apnoeic O_2 + CPAP; severe acidosis - keep the spontaneous drive and match minute ventilation; RV failure / tamponade - induce gently.

PEARLS & PITFALLS

- Resuscitate before you intubate - correct hypotension, hypoxia and acidosis; arrest happens peri-intubation.
- Do not chase intubation while the patient desaturates - a supraglottic or facemask rescue is not failure.
- Positioning is free medicine: ear-to-sternal-notch and ramping the obese patient triples the view.
- Declare CICO out loud and cut early; hesitation, not the incision, causes hypoxic brain injury.

References: Difficult Airway Society (DAS) 2015 & 2025 · DAS/ICS Critically Ill 2018 · MACOCHA (De Jong, AJRCCM 2013).

Educational aid; verify doses against local protocol and patient factors.