Recommendations for Airway Management in a Patient with Confirmed or Suspected COVID-19 Infection

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. Review protocols for donning and doffing PPE. Careful attention is required to avoid self-contamination.

Patients with confirmed or suspected COVID-19 infection:
- 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.
- Should have a high-quality HME (heat and moisture exchanging) filter, rated to remove at least 99.97% of airborne particles 0.3 microns or greater, placed between the ETT and circuit/reservoir bag at all times.

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:*
- PPE: N95 mask (or equivalent), eye protection or a face shield, an impermeable fluid resistant gown, disposable head cover, protective footwear, and 2 sets of gloves.
- Standard ASA monitoring should be applied before induction of anesthesia.

*Assign:*
- The most experienced anesthesia professional available to perform intubation, if possible. Avoid trainee intubation for sick patients.

*Discuss:*
- The plan for an unanticipated difficult intubation and ensure that desired rescue equipment is immediately available, including a supraglottic airway and a surgical airway kit.

*Avoid:*
- Awake fiberoptic intubation, unless specifically indicated. Atomized local anesthetic will aerosolize the virus. Consider alternate topicalization methods if indicated.

*Prepare to:*
- Preoxygenate for 5 minutes with 100% FiO₂, or until a desired target EtO₂ is achieved.
- Use equipment most familiar to the intubator; a video-laryngoscope is recommended as the primary intubating device to improve intubation success.

*Perform a Rapid Sequence Intubation (RSI):*
- Perform a RSI to avoid manual ventilation of patient's lungs and potential aerosolization of virus from airways.
- Depending on the clinical condition, the RSI may need to be modified.
- If manual ventilation is required, apply small tidal volumes, ensure an HME filter is in place.
- Immediately post intubation, inflate the ETT cuff before applying positive pressure ventilation

*Ensure:*
- A high quality HME filter is in place between the ETT/facemask and breathing circuit/reservoir bag at all times

*Dispose:*
- Resheath the laryngoscope immediately post intubation (double glove technique) or place within sealed bag. Seal all used airway equipment in a double zip-locked plastic bag. It must then be removed for decontamination and disinfection.

*Extubation:*
- Should occur under strict adherence to PPE. Consider the use of a protective cloth barrier to cover the mouth during extubation. Carefully dispose of contaminated equipment.

*Remember:*
- After removing protective equipment, avoid touching hair or face before washing hands.

*Track:*
- Symptoms of health care providers involved in airway manipulation, consider using an online registry such as IntubateCOVID at https://intubatecovid.knack.com/registry/add-intubation/

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