Awake Intubation
- Awake intubation should be the initial approach in a patient in whom a difficult intubation is anticipated, but who has adequate ventilation and is able to maintain oxygen saturation at greater than 90%. In this situation, rapid ablation of the patient's own respiratory drive by paralytics or general anesthesia may complicate airway management.

- Awake intubation offers several advantages:
  1) spontaneous ventilation is maintained, allowing gas exchange;
  2) airway reflexes are preserved, decreasing the risk of aspiration;
  3) muscle tone, and thus airway anatomy, are preserved; and
  4) the significant adverse effects of pharmacological agents used in intubation are avoided.

The awake approach can be used with virtually any intubation technique (surgical, direct laryngoscopy, blind nasal, fiberoptic, or an alternative device) and it is facilitated with topical or local anesthesia.

Difficult direct laryngeal intubation:
- can be facilitated by optimising patient position & use of BURP (backwards, upwards, rightwards pressure)

The failed airway:
- the airway is a failed airway when there have been three failed attempts at direct intubation
- failed airway can be divided into patients who can be ventilated & patients who cannot be ventilated

Options for the failed airway:
- bougie
- LMA
- fasttrack LMA
- combitube
- lighted stylet
- blind nasal
- bronchoscope

Non-surgical techniques for difficult intubation
- Awake Intubation
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Complications of the airway physical examination:
- Length of upper incisors
- Relation of maxillary and mandibular incisors during normal jaw closure
- Relation of maxillary and mandibular incisors during voluntary protrusion of lower incisors
- Intercanine distance
- Visibility of uvula
- Shape of palate
- Compliance of mandibular space
- Length of neck
- Thickness of neck
- Range of motion of head and neck

This table displays some findings of the airway physical examination that may suggest the presence of a difficult intubation. The decision to examine some of all of the airway components shown in this table depends on the clinical context and judgment of the practitioner. The table is not intended as a mandatory or exhaustive list of the components of an airway examination. The order of presentation in this table follows the "line of sight" that occurs during conventional oral laryngoscopy.