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.

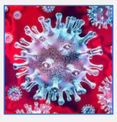
Patients with confirmed or suspected 2019-nCoV infected cases:

- 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:

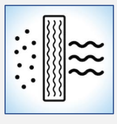
- Awake fiberoptic intubation, unless specifically indicated. Atomized local anesthetic can aerosolize the virus.

Prepare to:

- Preoxygenate for 5 minutes with 100% FiO2
- 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.

Anesthesia Patient Safety Foundation
www.apsf.org

Adapted from Kamming D, Gardam M, Chung F. I. Anaesthesia and SARS. Br J Anaesth 2003;90:715-18