

# **Awake Fiberoptic Intubation in a Burn Patient: A Case Report**

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# Learning Objectives

- Discuss the indications for awake flexible fiberoptic intubation
- Discuss our approach to awake flexible fiberoptic intubation



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# The Case

- ❖ 54 year old male with full body 3<sup>rd</sup> degree thermal burns after an accident 26 years prior requiring numerous reconstructive surgeries including extensive facial reconstructive surgery
- ❖ Face, neck and mouth extensively scarred
- ❖ Limited mouth opening and neck range of motion
- ❖ Presented for penetrating keratoplasty after corneal graft failure
- ❖ History of difficult intubation – had several awake fiberoptic intubations in the past
- ❖ Otherwise, patient had minimal medical co-morbidities further complicating airway management



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# Indications for awake FFI

- Gold standard in an anticipated or known difficult airway
- Gold standard in an anticipated or known difficult mask ventilation
- Advancements in airway device technology have made awake FFI a less commonly used airway technique
- Dangerous because skills atrophy



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# Our Approach to Awake FFI

- ❖ Administered glycopyrrolate 30 minutes prior to induction in preop
- ❖ Had patient place a tongue depressor with 2ml lidocaine 5% jelly in mouth during transport
- ❖ Topicalized airway with 5 ml atomized lidocaine 4%
- ❖ Administered Midazolam 2mg IV and Fentanyl 25mcg IV
- ❖ Placed oral airway with channel for bronchoscope
- ❖ Used Glidescope Bflex single-use bronchoscope
- ❖ Awake fiberoptic intubation preserves spontaneous ventilation
- ❖ Excellent airway topicalization dramatically improves the tolerability of the procedure



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# Local anesthetic usage in awake intubation

## MAXIMUM DOSE OF LIDOCAINE

4% lidocaine	40 mg/ml
5% lidocaine	50 mg/ml
Max dose (lido w/o epi)	4.5 mg/kg
Patient weight	95 kg
Max dose	427.5 mg
Dose given	300 mg



Thank You!



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