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Recommendations For Self-Protection When Intubating Suspected Or Confirmed Patients With COVID-19.

Interim Guideline

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The University of Toronto and our hospital partners are working closely to optimize the management of patients with suspected or confirmed infection with the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The World Health Organization now refers to the disease as COVID-19. This interim guideline has been developed with assistance from infection protection and control experts at the University of Toronto.

For routine care:

Use droplet and contact precautions for any suspected or confirmed cases of the COVID-19. Please consult your local infectious disease experts for information about routine care.

For non-routine care:

Includes aerosol-generating medical procedures and intubation. Please consult your local experts for updates.

1. Remember that YOUR personal protection is the priority. Please review the material and use appropriate isolation precautions. Plan ahead as it takes time to apply all the barrier precautions. Prior to intubation, review and practice donning and doffing the appropriate respiratory protection, gloves, face shield, and clothing. Pay close attention to avoid self-contamination.
2. Practice appropriate hand hygiene before and after all procedures.
3. Wear a fit-tested N95 respirator, face protector such as a shield, gown and gloves.
4. Limit the number of healthcare providers in the room where the patient is to be intubated.
5. The most experienced anesthetist available should perform the intubation, if possible.

6. Standard monitoring, i.v. access, instruments, drugs, ventilator and suction should be pre-checked.
7. Avoid awake fiberoptic intubation unless specifically indicated. Atomized local anesthetic might aerosolize the virus. Consider using a glidescope or a similar device.
8. Plan for rapid sequence induction (RSI) and ensure that a skilled assistant is able to perform cricoid pressure. RSI techniques may need to be modified if the patient has very high alveolar-arterial gradient and is unable to tolerate 30 s of apnea, or has a contraindication to succinylcholine. If manual ventilation is required, small tidal volumes should be applied.
9. Administer five minutes of preoxygenation with oxygen 100% and use a RSI technique in order to avoid manual ventilation of patient's lungs and potential aerosolization of virus from airways.
10. Ensure high efficiency hydrophobic filter is interposed between facemask and breathing circuit or between facemask and a self-inflating ventilation bag such as a Laerdal bag.
11. Intubate and confirm correct position of tracheal tube.
12. Institute mechanical ventilation and stabilize patient.
13. All airway equipment must be decontamination and disinfection according to appropriate hospital policies.
14. After removing protective equipment, avoid touching hair or face before washing hands.
15. The use of head covers is not standardized; however, most anesthesiologists would wear such a protective item.
16. It is important to develop a robust communication system so front-line healthcare providers can provide rapid feedback to policy makers and vice-versa. A previous report from the SARS epidemic emphasized the importance of timely information in the three domains of healthcare workers, processes and equipment.

References:

1. Caputo KM, Byrick R, Chapan MG, Orser BJ, Orser BA (2006) Intubation of SARS patients: infection and perspectives of healthcare workers. *Can J Anaesth*, 53(2):122-9