

## Bristol Awake Fiberoptic Recipe

This is what we use to topicalise the airway for nasal awake intubation on our training course. It is based on a technique used in the Norwich AFOI course. They published data on over 1300 endoscopies using this recipe<sup>i</sup>. 9mg/kg has been shown to be safe when applied to the mucosa using this technique<sup>ii</sup> No additional analgesia or sedation is necessary if you carefully apply the lidocaine as described and *take your time*.

1. Glycopyrrolate 3mcg/kg iv
2. 4ml of 4% lidocaine via nebuliser (50mg absorbed)
3. Xylometazoline (Otrivine) 1 puff each nostril
4. 2.5 ml of 5% lidocaine + 0.5% phynyephrine (co-phenylcaine) to turbinates of selected nostril. Don't sniff, coat the nasal mucosa. 125mg
5. 4 puffs of 10% lidocaine (Xylocaine) via atomiser to oropharynx, aiming for glottis. 40mg
6. 1ml aliquots of 4% lidocaine via epidural catheter within endoscope channel, up to 9mg/kg total. Specifically target: turbinates; above and below vocal cords.

The dose given as standard to each patient is 215mg. The subsequent dose of 4% spray as you go in ml is given by:

$$\frac{(\text{weight X } 9) - 215}{40}$$

We rarely require the full 9mg/kg. In clinical practice you may wish to use iv analgesia, such as remifentanyl. This is conveniently given by TCI and can be a substitute for the lidocaine nebuliser. We do not recommend sedative drugs like propofol or midazolam. Alternative vasoconstrictors are:

1. Cocaine via cotton buds – max 1.5mg/kg
2. 1ml 1:1000 adrenaline
3. Ephedrine 0.5% drops

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<sup>i</sup> <http://bit.ly/j3Zbhf>

<sup>ii</sup> <http://bit.ly/jltS1M>