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the vast majority of physicians who are expected to manage a difficult airway in the operating room are providers in the united states who attend a median of 10 and often more lectures on difficult airway management in their residency. however, in response to a survey, 25% of respondents described this type of training as inadequate for practicing clinicians who meet the asa difficult airway guidelines (e.g., as determined from their own self-assessment and their satisfaction with this type of training). 230 surveys of anesthesia providers in practice showed that 42% of anesthesiology providers in the united states said they do not provide sufficient airway education to residents and fellows and that approximately 45% of anesthesia providers in private practice had never received any airway training. in response to this information, self-directed reading and skill maintenance (e., using teaching tools such as videos) were recommended as alternative strategies for learning skills. these guidelines are intended for use by anesthesiologists and all other individuals who perform anesthesia care or airway management. the guidelines are intended to apply to all airway management and anesthetic care delivered in inpatient (e.g., perioperative, nonoperating room, emergency department, and critical care settings) and ambulatory settings (e., ambulatory surgery centers and office-based surgery and procedure centers performing invasive airway procedures). excluded are prehospital settings and individuals who do not deliver anesthetic care or perform airway management. these guidelines are also intended to serve as a resource for other physicians and patient care personnel who are involved in the care of difficult airway patients, including those involved in local policy development.



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cricothyrotomy and tracheostomy are classically indicated when the anticipated difficult airway is: expected (established by physical, mental, and physiological evidence such as the patient's response to therapeutic measures in the face of an anticipated difficult airway, and the clinical evaluation of the airway during induction of anesthesia.)unavoidable (obtained when there is an anticipated difficult airway and no alternative is available that would permit continuation of safe anesthetic care or airway management while still preserving the anticipated difficult airway or secure airway. determination of the anticipated difficult airway depends on the nature of the anticipated difficult airway, characteristics of the patient and anticipated surgical procedure.eliminated (the anticipated difficult airway has been resolved through another means that is feasible and would, if performed prior to the anticipated difficult airway, provide effective airway management and preservation of anticipated difficult airway, but it is already too late for prior management due to delays in obtaining consent for surgery, preoperative procedures, or for the patient to be transported to the operating room.) this mini review summarizes the current literature and guidelines for the emergent use of inflatable cricthyrotomy (ictr) and tracheostomy (ictr) for anticipated difficult airway management. the authors classify anticipated difficult airway management as routine, anticipated difficult airway, or anticipated difficult airway. this is adapted from the airway difficulties classification system, formerly known as the difficult airway society of the airway difficulties classification system. for anticipated difficult airway management, the first, second, and third category levels are defined as routine, difficult (already established), and anticipated difficult, respectively (table 1). this classification system is useful for defining the role of anticipated difficult airway and, thereby, guiding the definition of the levels of anticipated difficult airway management. 5ec8ef588b

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