⊗ HIGH FLOW NASAL OXYGEN

Before starting: ensure no contraindications to using HFNO

Anesthesia use ONLY

Indications

1. **Optimization of pre-oxygenation**
   - prior to induction of general anesthesia
2. **The anticipated difficult airway**
   - as an adjunct to maintain oxygenation during intubation
   - including awake fiberoptic intubation
3. **Extubation planning:**
   - to reduce risk of immediate respiratory complication

Preparation & Set-up

Attach nasal cannula: use standard nasal cannula with **a screw mount**

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Ensure APL valve is open & DO NOT apply positive pressure ventilation

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Recommended flow rates:
- 10L/min while patient is **awake**
- 10-40L/min while patient has **moderate sedation**
- 40-70L/min while patient is **under GA**

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Pre-oxygenation & Induction of GA

Before Induction:
Ensure APL valve is **open &** apply nasal cannula. Begin flow at 10L/min

Asleep intubation (DL, VL or FOI):
- Preoxygenate: facemask securely over patient's nose & mouth, with HFNO nasal cannula in place
- After Induction of anesthesia, set flows up to 40L/min and **do not use positive pressue ventilation**
- Maintain during laryngoscopy
- Perform intubation and confirm placement of ETT

Awake Fiberoptic Intubation
- Topicalize as usual
- HFNO via nasal cannula at 10L/min
- Sedation/analgesia, as indicated
- Increase flow rate (max 40L/min), **as tolerated by patient**
- Perform awake FOI and confirm placement of ETT

Immediately after intubation
Turn off HFNO, consider leaving cannula in place (for peri-extubation use)

Extubation

During emergence:
- restart flows through nasal cannula, max 40L/min

During extubation:
- Keep high flows running

After extubation:
- Wean down flows as able.
- APL valve stays open and no positive pressure ventilation with HFNO

Before transferring from OR:
- Wean down flow
- Assess airway patency

Transferring to PACU:
- Max O2 transport cylinders: 25L/min
- Ensure enough O2 is in the cylinder