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| 3-6 Laryngospasm and stridor v.1 |
| * Laryngospasm usually occurs when a patient is in a light plane of anaesthesia and their airway is stimulated in some way.
* Stridor is a sign and associated with laryngospasm (although it can have other causes).
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| Box A: DRUG DOSES FOR TREATMENT OF LARYNGOSPASM |
| 0.25-0.5 mg.kg-1 i.v.: * Propofol
* Rocuronium
* Atracurium
* Suxamethonium (also i.m. including tongue 4.0 mg.kg-1)
 |

 START.

❶ Call for help and inform theatre team of problem.

❷ Perform jaw thrust and stop any other stimulation.

❸ Remove airway devices and anything else that may be stimulating or obstructing the airway, e.g. suction catheters, blood or vomit (direct visualisation and suction if in doubt).

* A correctly positioned tracheal tube rules out laryngospasm.

❹ Give CPAP with 100% oxygen and face mask:

* Avoid over-vigorous attempts at lung inflation, as this may inflate the stomach.
* Insert an oro-pharyngeal and/or nasal airway if you are not sure that the airway is clear above the larynx.

❺ If problem persists:

* Continue CPAP.
* Deepen anaesthesia.
* Give a neuromuscular blocker (See Box A).

❻ Consider tracheal intubation particularly if likely to recur.

❼ Use nasogastric tube to decompress the stomach.

❽ Consider other causes (Box B).

❾ Consider whether guideline **2-3 Increased airway pressure** may help.

❿ Consider the appropriate strategy, location and support needed for waking the patient.

⓫ Continued airway and ventilation support may be necessary if aspiration has occurred or if the patient has developed negative-pressure pulmonary oedema.

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| Box B: ALTERNATIVES and MIMICS |
| Foreign bodyInfection of larynx/upper respiratory tractAnaphylaxisAirway tumourVocal cord paralysis | Intrinsic laryngeal or tracheal obstructionExtrinsic laryngeal or tracheal compression Sub-glottic stenosisLaryngo/tracheomalacia |

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| Box C: CRITICAL CHANGES |
| * Cardiac arrest → 2-1
* Hypoxia/desaturation/cyanosis → 2-2
* Increased airway pressure → 2-3
* Hypotension → 2-4
* Bradycardia → 2-6
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