- Direct trauma to the airway is rare accounting for less than 1% of traumatic injury seen in most major centres.

- The bony protection afforded to the airway by the sternum and mandible and plain radiography may demonstrate:
  (i) Air in soft tissues
  (ii) Pneumomediastinum
  (iii) Pneumothorax
  (iv) Cervical spine fracture

- CT scanning demonstrates:
  (i) Fractures of the cartilages
  (ii) Haematomas
  - It is used in stable patients with laryngeal tenderness, endolaryngeal oedema & small haematomas.

- Fibre optic laryngotracheoscopy:
  - Can demonstrate vocal cord dysfunction, integrity of the cartilaginous framework & laryngeal mucosa.
  - Can be used when adequate visualisation is not achieved with fibroptics.

- Airway management in patients with neck trauma is based upon a high index of clinical suspicion for cricoid or cervical tracheal injuries. Attempts at endotracheal intubation in patients with unsuspected cricoid injuries can be disastrous. Cricoid pressure or the attempted passage of an endotracheal tube may dislocate a fractured cricoid cartilage and/or entirely disrupt a partial tracheal transaction, producing complete airway obstruction.

- The equipment and personnel required to perform an immediate tracheostomy must be present prior to manipulation of an injured airway.

- Positive pressure ventilation can exacerbate air leaks and rapidly worsen symptoms from pneumothorax, pneumomediastinum, and air dissecting around airway structures. Whenever possible, the patient should be permitted to breathe spontaneously.

- Rapid induction of anaesthesia and neuromuscular blockade can rapidly produce loss of the airway and the inability to provide positive pressure ventilation.

- Attempts at direct laryngoscopy or intubation over a flexible bronchoscope may be futile because of bleeding within the airway or distortion of anatomic structures. The danger also exists that flexible bronchoscopy may occlude the airway or precipitate airway obstruction in patients with critical airway stenosis.

- Under ideal circumstances, pre-oxygenation followed by awake flexible bronchoscopy may permit evaluation of airway injuries and safe endotracheal intubation.

- Prior induction of general anaesthesia, using a potent inhalation anesthetic such as sevoflurane, while maintaining spontaneous ventilation, may be appropriate in some patients. This approach can permit rigid laryngoscopy and rigid bronchoscopy while maintaining spontaneous ventilation. These techniques may be preferable when bleeding or debris obscure the airway, making fibreoptic examination impossible. If endotracheal intubation appears unsafe, the patient is unstable or the airway is lost, immediate tracheostomy is the only appropriate choice.

- When the trachea itself is injured, it is preferable to conserve normal trachea by placing the tracheostomy through the damaged area. This will facilitate subsequent surgical repair of the trachea.

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