

### AIRWAY MANAGEMENT

Choose from the list of options the first-line most appropriate airway management in the following clinical scenario.

A 65 year old man who is a relative of a patient has collapsed in the out-patient waiting room. He is unresponsive and not breathing spontaneously.

- A. Blind nasal endotracheal intubation
- B. Extra-corporeal membrane oxygenation (ECMO)
- C. Jaw thrust
- D. Mouth to mouth ventilation
- E. Nasopharyngeal airway
- F. Needle cricothyroidotomy
- G. Oral endotracheal intubation
- H. Oropharyngeal airway
- I. Percutaneous tracheostomy
- J. Recovery position
- K. Surgical cricothyroidotomy
- L. Surgical tracheostomy

### AIRWAY MANAGEMENT

Choose from the list of options the first-line most appropriate airway management in the following clinical scenario.

A 20 year old man is brought in to A&E Department following a road traffic accident. He has an obvious laryngo-tracheal disruption and increasing respiratory distress.

- A. Blind nasal endotracheal intubation
- B. Extra-corporeal membrane oxygenation (ECMO)
- C. Jaw thrust
- D. Mouth to mouth ventilation
- E. Nasopharyngeal airway
- F. Needle cricothyroidotomy
- G. Oral endotracheal intubation
- H. Oropharyngeal airway
- I. Percutaneous tracheostomy
- J. Recovery position
- K. Surgical cricothyroidotomy
- L. Surgical tracheostomy

### AIRWAY MANAGEMENT

Choose from the list of options the first-line most appropriate airway management in the following clinical scenario.

A 73 year old elective surgical patient whom the anaesthetist is unable to intubate or ventilate.

- A. Blind nasal endotracheal intubation
- B. Extra-corporeal membrane oxygenation (ECMO)
- C. Jaw thrust
- D. Mouth to mouth ventilation
- E. Nasopharyngeal airway
- F. Needle cricothyroidotomy
- G. Oral endotracheal intubation
- H. Oropharyngeal airway
- I. Percutaneous tracheostomy
- J. Recovery position
- K. Surgical cricothyroidotomy
- L. Surgical tracheostomy

### CLEFT PALATE SURGERY

What would be the most appropriate operative procedure in the following circumstances?

A complete cleft of the soft and hard palate in an infant aged nine months.

- A. Alveolar bone graft
- B. Hyne's pharyngoplasty
- C. Palatal re-repair of muscle and oral z-plasty
- D. Palate re-repair of muscle (secondary surgery)
- E. Pre-maxillary set-back
- F. Primary palatal repair with radical muscle repositioning
- G. Prosthetic management
- H. Two-layer local flap closure
- I. Von Langenbeck repair with no muscle dissection
- J. Wardill-Kilner push back

### CLEFT PALATE SURGERY

What would be the most appropriate operative procedure in the following circumstances?

A five year old child with a history of cleft palate repair at nine months. He has moderately severe velopharyngeal dysfunction with hypernasal speech. The palate is of adequate length, however, there is good evidence of anterior levator insertion clinically and on lateral videofluoroscopy.

- A. Alveolar bone graft
- B. Hyne's pharyngoplasty
- C. Palatal re-repair of muscle and oral z-plasty
- D. Palate re-repair of muscle (secondary surgery)
- E. Pre-maxillary set-back
- F. Primary palatal repair with radical muscle repositioning
- G. Prosthetic management
- H. Two-layer local flap closure
- I. Von Langenbeck repair with no muscle dissection
- J. Wardill-Kilner push back

### CLEFT PALATE SURGERY

What would be the most appropriate operative procedure in the following circumstances?

A six year old child with a history of congenital cleft palate who has previously had a palate re-repair. This has resulted in significantly improved palatal function with active levator lift within the posterior soft palate. The speech remains hypernasal and videofluoroscopy confirms a persistent 5.00 mm nasopharyngeal gap. No adenoidal pad can be seen.

- A. Alveolar bone graft
- B. Hyne's pharyngoplasty
- C. Palatal re-repair of muscle and oral z-plasty
- D. Palate re-repair of muscle (secondary surgery)
- E. Pre-maxillary set-back
- F. Primary palatal repair with radical muscle repositioning
- G. Prosthetic management
- H. Two-layer local flap closure
- I. Von Langenbeck repair with no muscle dissection
- J. Wardill-Kilner push back