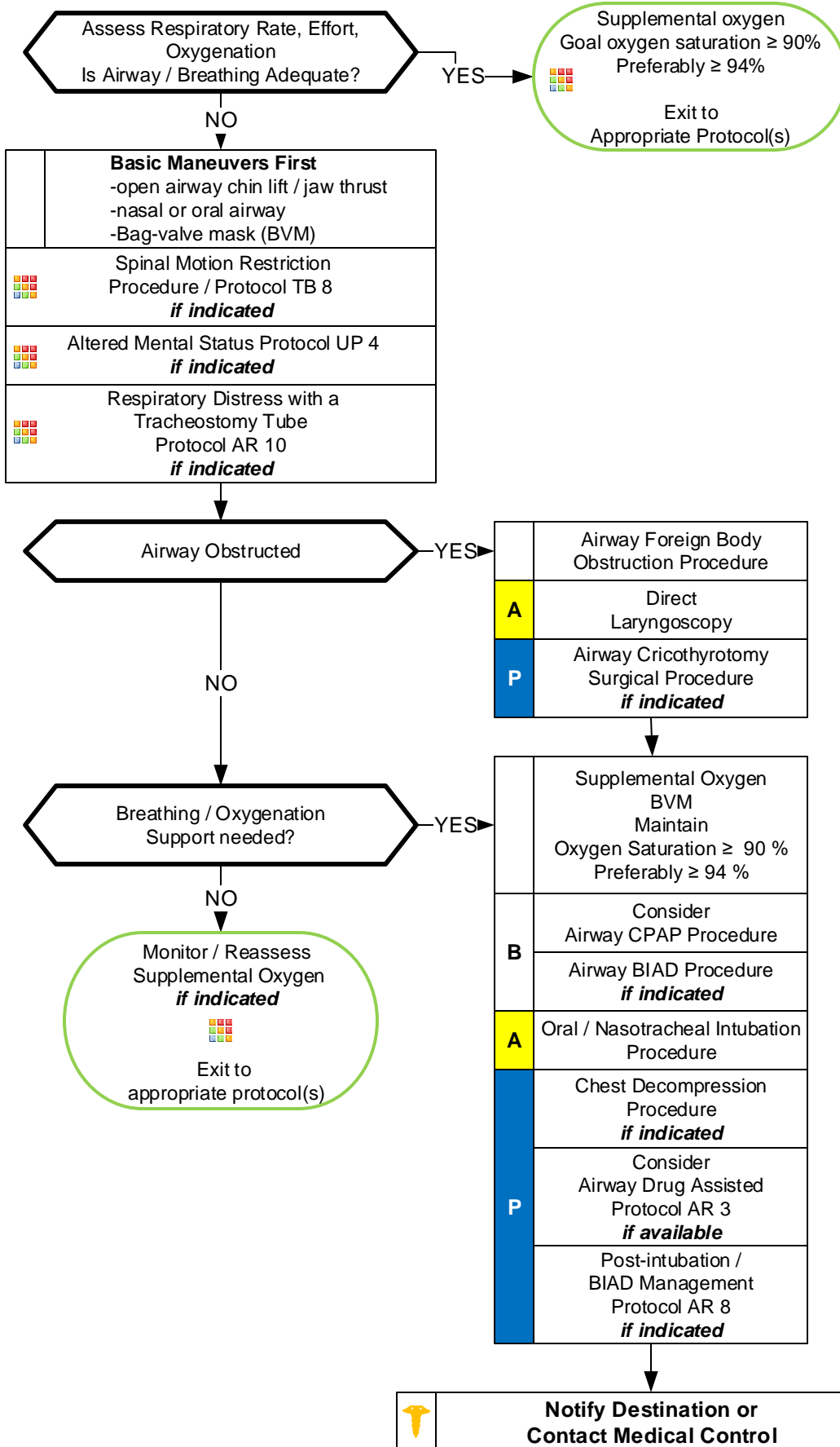


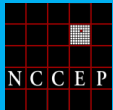


# Adult Airway



Protocols AR 1, 2, and 3 should be utilized together (even if agency is not using Drug Assisted Airway Protocol) as they contain useful information for airway management.

Unable to Ventilate and Oxygenate ≥ 90% during or after one (1) or more unsuccessful intubation attempts . and/or Anatomy inconsistent with continued attempts. and/or Three (3) unsuccessful attempts by most experienced Paramedic/ AEMT.  
Exit to Adult Failed Airway Protocol AR 2



# Adult Airway

## Pearls

- See Pearls section of protocols AR 2 and 3.
- For the purposes of this protocol a secure airway is when the patient is receiving appropriate oxygenation and ventilation.
- If an effective airway is being maintained by BVM with continuous pulse oximetry values of  $\geq 90\%$ , it is acceptable to continue with basic airway measures.
- Intubation Attempt is passing the laryngoscope blade past the teeth or ETT inserted into the nasal passage.
- Capnometry or capnography is mandatory with all methods of intubation. Continuous capnography (EtCO<sub>2</sub>) is strongly recommended for the monitoring of all patients with a BIAD and mandatory with monitoring of an endotracheal tube.
- Ventilatory rate should be 8-10 per minute to maintain a EtCO<sub>2</sub> of 35-45. Avoid hyperventilation.
- Anticipating the Difficult Airway and Airway Assessment
  - Difficult BVM Ventilation (MOANS):** Mask seal difficulty (hair, secretions, trauma); Obese, obstruction, OB – 2d and 3d trimesters; Age  $\geq 55$ ; No teeth; Stiff lungs or neck
  - Difficult Laryngoscopy (LEON):** Look externally for anatomical problems; Evaluate 3-3-2 (Mouth opening should equal 3 of patients finger's width, mental area to neck should equal 3 of patient's finger's width, base of chin to thyroid prominence should equal 2 of patients finger's width); Obese, obstruction, OB – 2d and 3d trimesters; Neck mobility limited.
  - Difficulty BIAD (RODS):** Restricted mouth opening; Obese, obstruction, OB – 2d and 3d trimesters; Distorted or disrupted airway; Stiff lungs or neck
  - Difficulty Cricothyrotomy / Surgical Airway (SMART):** Surgery scars; Mass or hematoma, Access or anatomical problems; Radiation treatment to face, neck, or chest; Tumor.
- It is strongly encouraged to complete an Airway Evaluation Form with any BIAD or Intubation procedure.
- Nasotracheal intubation: Procedure requires spontaneous breathing and may require considerable time, exposing patient to critical desaturation. Contraindicated in combative, anatomical disrupted or distorted airways, increased ICP, severe facial trauma, basal skull fracture, and head injury. Orotracheal route is preferred.
- Maintain spinal motion restriction for patients with suspected spinal injury.
- AEMT and Paramedics should consider using a BIAD if oral-tracheal intubation is unsuccessful.
- During intubation attempts use External Laryngeal Manipulation to improve view of glottis.
- Gastric tube placement should be considered in all intubated patients if available or time allows.
- It is important to secure the endotracheal tube well to better maintain ETT placement. Manual stabilization of endotracheal tube should be used during all patient moves / transfers.
- **DOPE:** Displaced tracheostomy tube / ETT, Obstructed tracheostomy tube / ETT, Pneumothorax and Equipment failure.