not touch the xiphoid process of the sternum or the lower margins of the ribs. Up to five thrusts are repeated in rapid succession until the FB is expelled.

FIG 21-19 Abdominal thrusts in standing child for relief of foreign body (FB) obstruction.

It is neither necessary nor desirable to squeeze or compress the arms during the procedure. It is not a punch or a bear hug. The child may vomit after relief of the obstruction and should be positioned to prevent aspiration. After breathing is restored, the child should receive medical attention and be assessed for complications. If the child is coughing, allow him or her to relieve the obstruction this way.

The success of the technique is primarily a result of the obstruction occurring at the end of a maximum respiration. The victim is most likely to choke on food during inspiration; therefore, the tidal volume plus expiratory reserve volume is present in the lungs. When pressure is exerted on the diaphragm by the maneuver, the food bolus is ejected with considerable force by this trapped air.

If the victim is breathing or resumes effective breathing after emergency interventions, place him or her in the recovery position —move the head, shoulders, and torso simultaneously and turn onto the side. The leg not in contact with the ground may be bent and the knee moved forward to stabilize the victim (Fig. 21-20). The victim should not be moved in any way if trauma is suspected and