King Airway® Placement – 30.110

DEFINITION:
The KING LT-D is a disposable supraglottic airway created as an alternative to endotracheal intubation or mask ventilation. The KING LT-D is designed for positive pressure ventilation as well as for spontaneously breathing patients.

INDICATIONS:
A. Use of the King LTD airway is indicated if endotracheal intubation cannot be performed and the patient needs a secure airway.
B. Attempts at endotracheal intubation have been unsuccessful.

CONTRAINDICATIONS:
A. Intact gag reflex
B. Airway obstruction.
C. Known or suspected caustic ingestion.
D. Known esophageal disease.

PROCEDURE:
A. Attach pulse oximeter and monitor oxygen saturation.
B. If vomitus, blood or other foreign material is present in the hypopharynx, rapid and aggressive suctioning and/or manual removal must be done prior to placement of the King Airway.
C. Ventilate with BVM to optimize oxygen saturation prior to King LTD intubation especially if several endotracheal intubations were attempted.
D. Estimate patient's height (for sizing of King LTD airway) and select proper tube size.
   a. 35 - 45 inches Size 2 (Green)
   b. 41 – 51 inches Size 2.5 (Orange)
   c. 4 – 5 feet tall Size 3 (Yellow)
   d. 5 – 6 feet tall Size 4 (Red)
   e. 6 – 7 feet tall Size 5 (Purple)
E. Lubricate the posterior distal end of the King Airway with a water-soluble gel.
F. Place patients head into a "sniffing" position. If suspected or potential cervical spine injury keep patients head in neutral position during insertion.
G. Using a midline approach, introduce tip into mouth and advance behind base of tongue. The blue orientation line on the tube should face the chin of the patient.
H. Without using excessive force, advance tube until the base of the connector is aligned with the teeth and/or gums. Never force the tube into position.
I. Inflate the cuffs using the appropriate volume of air.

King Airway Inflation Volumes		
Size	LTS-D	LT-D
#2	-	25-35 ml
#2.5	-	30-40 ml
#3	40-55 ml	45-60 ml
#4	50-70 ml	60-80 ml
#5	60-80 ml	70-90 ml

J. Attach bag valve device to the tube with supplemental oxygen. While gently bagging the patient to assess ventilation, simultaneously withdraw the King Airway

until ventilation is easy and free-flowing (large tidal volume with minimal airway pressure).

K. Listen for lung sounds in both lung fields and over epigastrium.
L. As soon as feasible, secure the King Airway with an endotracheal tube holder.
M. Monitor oxygen saturation, chest rise, and ETCO2 monitor.
N. After successful placement, continue to monitor for adequate ventilations, possible displacement tube and or cuff failure.

SUCTIONING THROUGH THE KING LTS-D:

A. Use of the gastric access lumen for suctioning and removal of stomach contents will be at the discretion of the user.
B. Attach a maximum size 18 Fr suction catheter to a portable suction unit
C. If necessary, lubricate the catheter with a water-soluble gel.
D. Insert the suction catheter into the opening of the gastric access lumen, and advance to the maximum depth.
E. Turn on suction unit and maintain continuous suction until there is no further return of stomach contents.
F. After detaching suction unit, the catheter may be left in place to prevent any additional stomach contents from being expelled from the gastric access lumen.
G. If active suctioning is not performed, a suction catheter may be placed in the gastric access lumen to act as a passive vent, and to prevent stomach contents from being expelled from the lumen.

NOTES & PRECAUTIONS:

A. It is important that the tip of the device be maintained in the patient's midline. Keeping the tip at midline assures that the distal tip is properly placed in the hypopharynx and upper esophagus.
B. Depth of insertion is key to providing a patent airway. A shallow initial insertion will require deflation of the cuffs to advance the tube deeper.
C. It is extremely important to open the airway and ensure that the tip of the King Airway advances past the base of the tongue.
D. Unlike the Combitube, the King LTD device is not designed to ventilate the patient if placed in the trachea. If unable to ventilate the patient after placement deflate balloons and adjust depth of tube to optimize ventilation