DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: AIRWAY OBSTRUCTION **Ref. No. 1234**

Base Hospital Contact: Required for patients with severe respiratory distress and/or respiratory arrest.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)* ❶

2. Administer **Oxygen** prn *(MCG 1302)*
   High flow Oxygen 15 L/min for all patients with impending respiratory arrest due to severe airway obstruction

3. For physical obstruction from foreign body:
   If patient unable to speak but is conscious, perform 5 abdominal thrusts; reassess, if patient becomes unconscious lower to ground and begin chest compressions

   If patient is unconscious, initiate CPR X 2 minutes
   Perform direct laryngoscopy to visualize potential obstruction when indicated
   Remove visible foreign body with Magill forceps

4. If patient has an Unmanageable Airway *(MCG 1302)***:**
   Initiate immediate transport to MAR and **CONTACT BASE** en route

5. Initiate cardiac monitoring *(MCG 1308)*

6. If patient is conscious and spontaneous ventilation is adequate:
   Monitor in position of comfort

7. Consider specific presentation:
   For suspected anaphylaxis treat per *TP 1219, Allergy*

   For stridor:
   Epinephrine (1mg/mL solution) administer 5mg (5mL) via neb
   Repeat x1 in 10 min prn
   Prepare to manage airway if patient's condition deteriorates

   For visible airway/tongue swelling:
   Epinephrine (1mg/mL) administer 0.5mg (0.5mL) IM
   Repeat every 10 min prn x2, maximum total 3 doses

   For patients with a tracheostomy and suspected obstruction: ❷
   Attempt suctioning
   Remove and clean inner cannula with saline if present; replace if positive-pressure ventilation required ❸
   If the obstruction is not relieved, remove entire tracheostomy tube and replace with a new tracheostomy or 6.0mm endotracheal tube ❹
   If a new tube cannot be placed, cover stoma and attempt BMV first via the mouth. If no chest rise attempt BMV over stoma with a small mask

8. Establish vascular access prn *(MCG 1375)*

SPECIAL CONSIDERATIONS

❶ In evaluation of patient with suspected airway obstruction, assessment of the airway should include the tongue and posterior oropharynx, including uvula and tonsillar pillars.

❷ Common tracheostomy emergencies include obstruction of the tracheostomy tube and bleeding. There are different types of tracheostomy tubes, some with an inner cannula and/or obturator. The obturator obstructs airflow and is only used during insertion. The inner cannula allows for connection to a ventilator or bag mask for positive pressure ventilation. There are both cuffed and uncuffed tracheostomy tubes. If the tracheostomy does not have a cuff (balloon inflated in the trachea indicated by a side port), the airway is not protected against aspiration and air can leak out through the mouth during positive-pressure ventilation. If respiratory failure occurs in a patient with an uncuffed tracheostomy tube, it should be replaced with a cuffed endotracheal tube if feasible in order to facilitate positive-pressure ventilation. For bleeding direct pressure should be applied and suctioning as needed to reduce aspiration of blood.

❸ The inner cannula is required to attach a ventilator or bag mask to a tracheostomy for positive-pressure ventilation. It may become obstructed with secretions; remove, clean with saline, and replace once obstruction relieved.

❹ Removal and reinsertion of the tracheostomy tube is contraindicated if the tracheostomy is < 1 week old because the stoma has not fully formed and a false tract may be created. Once the stoma has matured, a tracheostomy can be safely removed and replaced when necessary. If a flexible intubation guide (e.g., Bougie) can be inserted, it may be used to guide the removal and reinsertion of the tracheostomy or endotracheal tube.