



Treatment Protocol: AIRWAY OBSTRUCTION

Ref. No. 1234-P

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 15L/min for all patients with impending respiratory arrest/failure ❷
3. For airway obstruction due to foreign body:
If patient unable to speak but is conscious, perform 5 abdominal thrusts or, if <1 year, alternate 5 back blows and 5 chest thrusts
If patient becomes unconscious lower to ground and begin chest compressions

If patient is unconscious, initiate CPR x 2 min
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 EDAP and **CONTACT BASE** en route
5. Advanced airway prn for patients of appropriate age and size (*MCG 1302*)
6. Initiate cardiac monitoring (*MCG 1308*)
7. If patient is conscious and spontaneous ventilation is adequate:
Monitor in position of comfort
8. Consider specific presentation:
For suspected anaphylaxis treat per *TP 1219-P, Allergy*

For stridor concerning for croup or tracheitis:
<1 year old: **Epinephrine (1mg/mL) 2.5mL via neb**, dose per *MCG 1309* ❷
≥ 1 year of age: **Epinephrine (1mg/mL) 5mL via neb**, dose per *MCG 1309* ❷
Repeat x1 in 10 min prn, maximum 2 total doses prior to Base contact
Prepare to manage airway if patient's condition deteriorates

For visible airway/tongue swelling:
Epinephrine (1mg/mL) 0.01mg/kg IM dose per *MCG 1309*
Repeat every 10 min prn x2, maximum 3 total doses prior to Base contact

For patients with a tracheostomy and suspected obstruction: ❸
Attempt suctioning



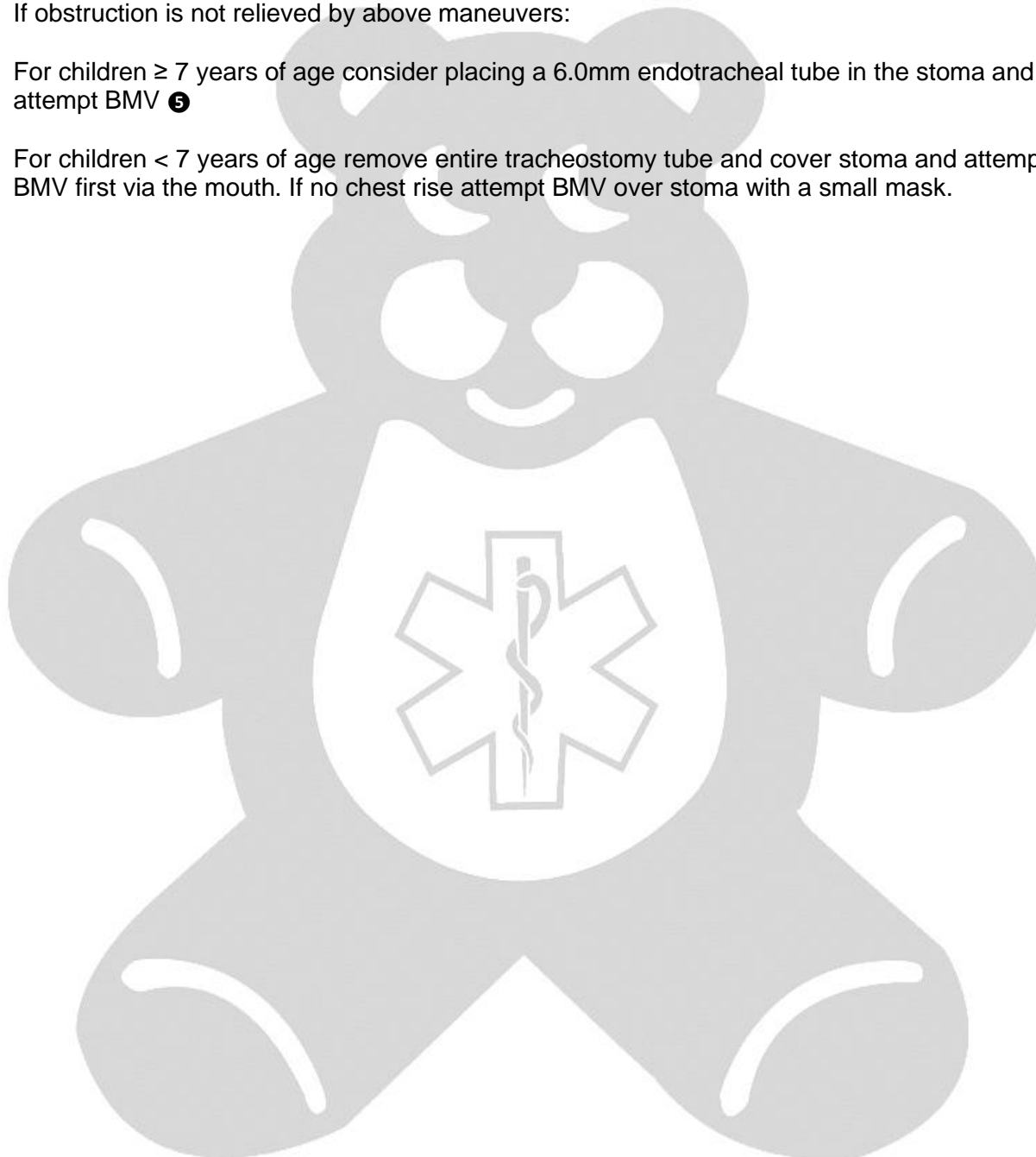
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Remove and clean inner cannula with saline; replace if positive-pressure ventilation required ④
If obstruction is not relieved by above maneuvers:

For children ≥ 7 years of age consider placing a 6.0mm endotracheal tube in the stoma and attempt BMV ⑤

For children < 7 years of age remove entire tracheostomy tube and cover stoma and attempt BMV first via the mouth. If no chest rise attempt BMV over stoma with a small mask.





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 Consider blow-by to avoid agitation in pediatric patients if a mask cannot be tolerated (e.g., infants and toddlers).
- ❸ 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 usually only used during insertion. The inner cannula allows for connection to a ventilator or bag mask for positive pressure ventilation. Tracheostomy tubes may be cuffed (balloon inflated in the trachea as indicated by a side port) or uncuffed. If the tracheostomy does not have a cuff, 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 the appropriate size is available) 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.
- ❹ 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 is relieved. If it cannot be replaced, cover the stoma with gauze and begin BMV via the mouth. If no chest rise, place a small mask over the stoma and begin stoma-mask ventilation.
- ❺ 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.