810

OROTRACHEAL INTUBATION

PAC REVISION: June 2024

(Signature On-file)
David Duncan, EMS Agency Medical Director

INDICATIONS:

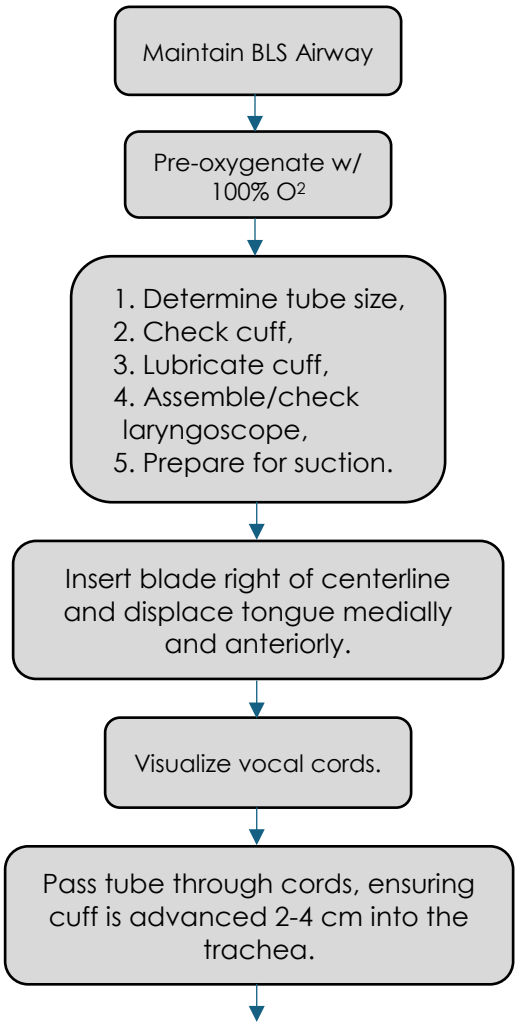
- Emergency control of compromised airway in breathing/non-breathing patients
- Control ventilation and provide airway protection
- Respiratory depression secondary to ETOH, OD, CVA
- Respiratory distress secondary to smoke inhalation, asthma, emphysema
- Patients with GCS of 8 or less
- Other clinical settings deemed appropriate by base station

CONTRAINDICATIONS:

- Suspected epiglottitis
- Oropharyngeal abscess
- Anatomic disruption of the oropharynx
- Pediatric patient

COMPLICATIONS:

- May induce vomiting
- Damage to dental structures
- Esophageal intubation
- Laryngeal trauma
- Hypoxia (prolonged attempts)
- Cervical cord damage in patients with unsuspected cervical-spine injury
- Cervical spine fracture in patients with arthritis/poor cervical mobility
- Ventricular arrhythmias in hypothermic patients
- Induction of pneumothorax (forceful bagging, traumatic insertion, etc.)

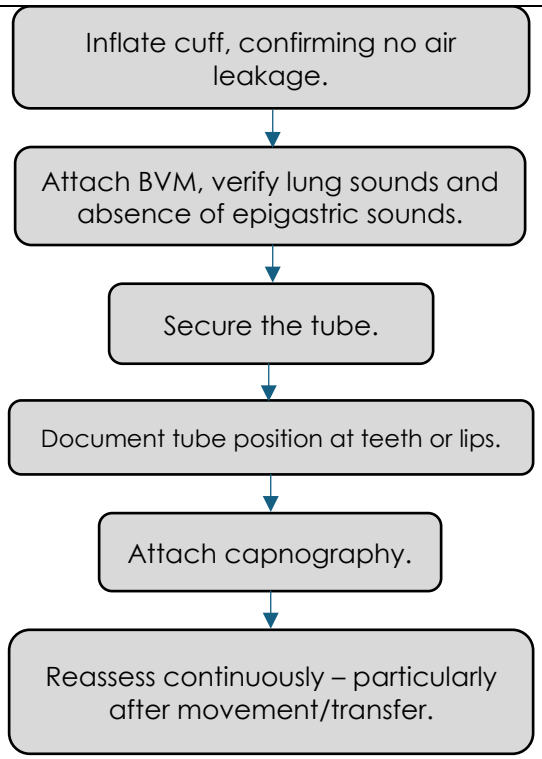


PEARLS:

- Maintain in-line stabilization in all patients with suspected cervical spine injury.
- Consider using a cervical collar to prevent dislodge.
- Have suction ready.
- Limit attempt duration to < 30 seconds.
- If visualization of vocal cords is difficult, stop and re-ventilate the patient before trying again.

Introducer (Bougie) Guidelines:

- Confirm that the Bougie is in the trachea by feeling tracheal rings and by a firm stop within 40 cm.
- If no rings are felt and the Bougie can be advanced without a firm stop then it is likely in the esophagus.
- Utilize second person to advance ET tube over the Bougie and through the cords so cuff is correct distance past cords, and remove bougie.


Inflate cuff, confirming no air leakage.
Attach BVM, verify lung sounds and absence of epigastric sounds.
Secure the tube.
Document tube position at teeth or lips.
Attach capnography.
Reassess continuously – particularly after movement/transfer.