MCHD	PROCEDURES PROC-01H	IGEL AIRWAY	Page 1 of 1 Last Revision: 03/27/2019

Indications:

- Unsuccessful intubation
- CPR

Contraindications:

- Gag reflex
- Caustic ingestion or extensive airway burns
- Obvious upper airway anatomical abnormalities making placement difficult

Complications:

- Airway trauma
- Gastric distension
- Inadequate ventilation/oxygenation

Procedure:

- Choose the correct size igel based on the patients weight and product packaging.
- Apply a water based lubricant to the posterior aspect of the igel.
- Position the head – the ideal head position for insertion of the igel is the sniffing position however, it can also be used with the head in a neutral position.
- Hold the igel along the bite block with the dominate hand. With the non-dominate hand hold the mouth open.
- Introduce the leading soft tip into the mouth of the patient toward the hard palate.
- Glide the device downwards and backwards along the hard palate with a continuous, but gentle push until a definitive resistance is felt. Do not apply excessive force.
- The tip of the igel should be located into the upper esophageal opening and the cuff should be located against the laryngeal framework. The incisors should be resting on the integral bite block. There is NO cuff to inflate.
- Confirm proper position by auscultation of bilateral breath sounds and capnography.
- Secure the igel using included strap.
- Verify placement after every patient transfer.

Considerations:

- A suction port in the igel airway allows a soft tip suction catheter to be placed in the stomach through the tube.
- If unable to place the igel after two (2) attempts discontinue the procedure and continue ventilations via a bag-valve-mask.
- The igel airway *does not protect* the airway from the effects of regurgitation and aspiration.
- Inability to ventilate the patient after placement suggests igel is malpositioned.