

Purpose: To provide the procedure for management of an obstructed airway.

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I. Indications

- A. Complete or partial obstruction of the airway due to a foreign body
- B. Complete or partial obstruction of the airway due to airway swelling from anaphylaxis, croup, or epiglottitis; may need to refer to Respiratory Insufficiency Protocol.
- C. Patient with unknown illness or injury who cannot be ventilated after the airway has been properly opened.

II. Technique

A. Complete Airway Obstruction

1. Conscious Adult Patient

- a. Perform Foreign Body Airway Obstruction Management Procedure for the Conscious Patient according to AHA or ARC Guidelines.

2. Unconscious Adult Patient

- a. Perform Foreign Body Airway Obstruction Management Procedures for the Unconscious Patient according to AHA or ARC Guidelines.
- b. In the event two sets of abdominal thrusts are unsuccessful at removing the obstruction and the patient remains unconscious and apneic and cannot be ventilated, a laryngoscope may be gently used to attempt to visualize a foreign body. If a foreign body can be visualized, Magill forceps may be used to assist in removal of the foreign body.
- c. **If the obstruction is not relieved**, proceed to Needle Cricothyroidotomy as outlined in the Airway/Oxygenation Procedure.
- d. **When the obstruction is relieved:**
 - 1) Keep or place patient on the side to help protect the airway.
 - 2) Apply high flow oxygen per Airway/Oxygenation Procedure.
 - 3) Assess the adequacy of ventilations and support as needed.
 - 4) Consider intubation if appropriate.
 - 5) Suction aggressively.

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B. Partial Airway Obstruction

1. Have patient assume a position of comfort, unless risk of spinal injury, then immobilization is indicated.
2. Apply high flow O₂ at 10 to 15 lpm by a non-rebreather mask.
3. Suction upper airway secretions as appropriate.
4. As long as the patient is moving air or coughing, support airway attempts.
5. If patient demonstrates evidence of deterioration (change in mental status, inability to ventilate), treat as complete airway obstruction.

III. Special Considerations

- A. The above techniques for management of obstructed airway apply as well to children and infants with the following exceptions in infants:
 1. Five back blows followed by five chest thrusts are to be used rather than abdominal thrusts.
 2. Finger sweep should only occur if foreign body is visualized. Blind finger sweeps are NOT performed in infants.
 3. Needle cricothyroidotomy should not be performed in patients less than 8 years old without medical control permission.
- B. Patients with partial airway obstruction can be very uncomfortable. Abdominal thrusts will not be effective and may be injurious to the patient who is still ventilating. No attempts should be made to relieve a partial airway obstruction. However, be ready to intervene immediately if complete airway obstruction develops.
- C. Vomiting and aspiration commonly occur after relief of an airway obstruction. Be prepared to quickly and aggressively suction the patient.
- D. The use of a laryngoscope and Magill forceps should not occur in the context of a partial airway obstruction.

