Obstructed Airway Management

Indications:

1. Complete or partial obstruction of the airway due to a foreign body.
2. Complete or partial obstruction of the airway due to airway swelling from anaphylaxis, croup, or epiglottitis; refer to **Respiratory Distress Protocol**.
3. Complete or partial obstruction due to burns or trauma to the airway
4. Patient with unknown illness or injury who cannot be ventilated after the airway has been properly positioned

Management:

Complete Foreign Body Airway Obstruction

Pre-Medical Control
MFR/EMT/SPECIALIST/PARAMEDIC

1. For the conscious patient, confirm severe airway obstruction through assessment or by asking the patient if they are choking, depending on the age of the patient
2. Give abdominal thrusts/Heimlich maneuver, or chest thrusts for pregnant or obese patients, to adults and children one (1) year or older
3. Give five (5) back slaps and five (5) chest thrusts to infants, less than one (1) year
4. Repeat the age appropriate maneuver until effective, or until the patient becomes unconscious
5. If the foreign body is removed, assess the adequacy of the patient's breathing and support ventilations as needed
6. If the patient becomes unconscious, begin CPR
7. Look in the mouth when opening the airway during CPR. Use finger sweep only to remove visible foreign bodies

SPECIALIST

8. For the unconscious patient, perform direct laryngoscopy and attempt removal using Magill forceps.
9. Removal may be facilitated with simultaneous abdominal thrusts, or chest thrusts.
10. If unable to dislodge/remove the foreign body and unable to ventilate the patient using basic airway maneuvers, proceed to orotracheal intubation. (See **Emergency Airway Procedure**),
    A. Intubate the right main-stem bronchus purposefully, causing the obstruction to enter the bronchus, then retract the tube to a proper depth and ventilate the left lung.
    B. Ensure that those taking over care are fully aware of the situation, whether at the hospital or if there is a transfer of care to a transporting unit.

PARAMEDIC

8. For the unconscious patient, perform direct laryngoscopy and attempt removal using Magill forceps.
9. Removal may be facilitated with simultaneous abdominal thrusts, or chest thrusts.
10. If unable to dislodge/remove the foreign body and unable to ventilate the patient using basic or advanced airway procedures, perform a cricothyrotomy as permitted by local medical control (See **Emergency Airway Procedure**)

Partial Foreign Body Airway Obstruction

Pre-Medical Control
MFR/EMT/SPECIALIST/PARAMEDIC

1. Initial Treatment
   A. Have the patient assume a position of comfort
   B. Provide supportive care and supplemental oxygen, if needed, as long as the patient is moving air or coughing. Do not attempt active intervention to relieve a partial obstruction.
   C. If patient demonstrates evidence of deterioration (change in mental status, inability to ventilate), treat as though it were a complete airway obstruction.
2. When the foreign body obstruction is relieved
   A. Place in recovery position or position of comfor**t**
   B. Refer to **Emergency Airway Procedure** as needed
3. Airway Swelling or Anatomical Obstruction
   A. See **Anaphylaxis/Allergic Reaction Protocol** as appropriate
   B. Refer to **Emergency Airway Procedure** for prompt intubation in burn or trauma patients with airway compromise due to swelling or injury, or for cricothyrotomy (as approved by local medical control) for obstruction resulting in inability to ventilate the patient and inability to intubate.
4. Initiate rapid transport

SPECIAL CONSIDERATIONS:

1. Vomiting and or aspiration commonly occur after relief of an airway obstruction. Be prepared to quickly and aggressively suction the patient.