# *Emergency Airway (Supplement)*
# *LMA Supreme ®*

*Supraglottic Airway Required Documentation*

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|---|---|
| Size and Type of LMA Supreme airway used | Time(s) attempted |
| Number of attempts | Suctioning required before placement |
| Ventilation compliance | Chest rise with ventilation |
| Equality of Lung Sounds | Absence of Epigastric Sounds |
| Capnography used | ET $CO_2$ capnography reading |
| Method of Securing Airway | Any Complications with Procedure |
| Gastric decompression performed | |

**Indications:**
For use in unconscious patients without gag relx, that require ventilation. May be used as arescue device for failed endotracheal intuabation or as a primary advanced airway technique. Consider in cardiac arrest patients to minimize interruptions in compressions.

**Contraindications:**
1. Responsive patients with a gag reflex
2. Patients who are under 4 feet
3. Patients in who caustic substance ingestion is suspected.

**Equipment:**
1. LMA SUPREME: Disposable Airway that does not have gastric access.
2. LMA SUPREME: Diposable Airway that provides gastric access to allow for gastric decompression using an 18 F gastric tube (preferred for adults).
3. Supplies: Water-soluble lubricant, bag-valv-mask, capnography, securing device.
4. Use appropriate size and inflation volumes for patient based on table below.

| Size | Patient Criteria | Inflation Volume |
|---|---|---|
| 3 | 30-50 kg | 15-30 ml |
| 4 | 50-70 kg | 45-60 ml |
| 5 | 70-100 kg | 45-60 ml |

**Procedure:**
5. Provide bag-valve-mask ventilation using 2-person technique with an oropharyngeal airway, avoiding hyperventilation, and performing pharyngeal suctioning as needed.
6. Test cuff inflation system by injecting the maximum inflation volume listed in table above for the size of the tube.
7. Deflate cuffs completely before insertion, leaving syringe attached to connector.
8. Lubricate the beveled distal tip and posterior aspect of the tube avoiding introduction of lubricant in or near the ventilatory openings.
9. Position the patient's head (ideal position is the sniffing position but the neutral position can be used).

10. Holding the LMA at the connector, hold the patient's mouth open and apply chin lift unless contraindicated due to trauma and/or spinal immobilization.
11. Introduce tip into the mouth and advance behind the base of the tongue. Never force the tube into position.
12. As the tip passes under tongue the tube should be midline.
13. Without exerting excessive force, advance the LMA until base of connector aligns with teeth or gums.
14. Inflate the cuff based on the listed volumes for the tube size used.
15. Attempt ventilation. If resistance is met and/or no chest rise occurs, carefully withdraw the airway approximately 1 cm at a time while attempting to ventilate. When airway is in supraglottic position, patient should easily ventilate and chest should rise and fall.
16. Attach bag, valve device and verify placement by ALL of the following criteria:
    a. Positive end-tidal CO2 levels by waveform capnography (preferred) or by use of colorimetric qualitative end-tidal CO2
    b. Rise and fall of chest
    c. Bilateral breath sounds
    d. Absent epigastric sounds
17. Secure the airway, preferably with a commercial tube holding device appropriate for the LMA
18. If there is any question about the proper placement of the LMA, deflate the cuffs and remove the airway, ventilate the patient with BVM for 30 seconds and repeat insertion procedure or consider other airway management options.
19. Continue to monitor the patient for proper airway placement throughout prehospital treatment and transport.
20. Following successful placement, consider gastric decompression using a lubricated 18F gastric tube, if available.
21. LMA should be removed if patient develops a gag reflex.
22. Alternatively, paramedics may sedate as needed for tube tolerance per **Patient Sedation Procedure**.