Base Hospital Contact: Required for patients with severe respiratory distress and/or respiratory arrest.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn (MCG 1302) 

2. Administer Oxygen prn (MCG 1302)
   High flow Oxygen 15 L/min for all patients with impending respiratory arrest due to severe airway obstruction

3. For physical obstruction from foreign body:
   If patient unable to speak but is conscious, perform 5 abdominal thrusts; reassess, if patient becomes unconscious lower to ground and begin chest compressions
   If patient is unconscious, initiate CPR X 2 minutes
   Perform direct laryngoscopy to visualize potential obstruction when indicated
   Remove visible foreign body with Magill forceps

4. If patient has an Unmanageable Airway (MCG 1302):
   Initiate immediate transport to MAR and CONTACT BASE en route

5. Initiate cardiac monitoring (MCG 1308)

6. If patient is conscious and spontaneous ventilation is adequate:
   Monitor in position of comfort

7. Consider specific presentation:
   For suspected anaphylaxis treat per TP 1219, Allergy
   For stridor:
   Epinephrine (1mg/mL solution) administer 5mg (5mL) via neb
   Repeat x1 in 10 min prn
   Prepare to manage airway if patient’s condition deteriorates
   For visible airway/tongue swelling:
   Epinephrine (1mg/mL) administer 0.5mg (0.5mL) IM
   Repeat every 10 min prn x2, maximum total 3 doses
   For patients with a tracheostomy and suspected obstruction:
   Attempt succioning
   Remove and clean inner cannula with saline if present; replace if positive-pressure ventilation required
   If the obstruction is not relieved, remove entire tracheostomy tube and replace with a new tracheostomy or 6.0mm endotracheal tube
   If a new tube cannot be placed, cover stoma and attempt BMV first via the mouth. If no chest rise attempt BMV over stoma with a small mask

8. Establish vascular access prn (MCG 1375)
SPECIAL CONSIDERATIONS

1. In evaluation of patient with suspected airway obstruction, assessment of the airway should include the tongue and posterior oropharynx, including uvula and tonsillar pillars.

2. Common tracheostomy emergencies include obstruction of the tracheostomy tube and bleeding. There are different types of tracheostomy tubes, some with an inner cannula and/or obturator. The obturator obstructs airflow and is only used during insertion. The inner cannula allows for connection to a ventilator or bag mask for positive pressure ventilation. There are both cuffed and uncuffed tracheostomy tubes. If the tracheostomy does not have a cuff (balloon inflated in the trachea indicated by a side port), the airway is not protected against aspiration and air can leak out through the mouth during positive-pressure ventilation. If respiratory failure occurs in a patient with an uncuffed tracheostomy tube, it should be replaced with a cuffed endotracheal tube if feasible in order to facilitate positive-pressure ventilation. For bleeding direct pressure should be applied and suctioning as needed to reduce aspiration of blood.

3. The inner cannula is required to attach a ventilator or bag mask to a tracheostomy for positive-pressure ventilation. It may become obstructed with secretions; remove, clean with saline, and replace once obstruction relieved.

4. Removal and reinsertion of the tracheostomy tube is contraindicated if the tracheostomy is < 1 week old because the stoma has not fully formed and a false tract may be created. Once the stoma has matured, a tracheostomy can be safely removed and replaced when necessary. If a flexible intubation guide (e.g., Bougie) can be inserted, it may be used to guide the removal and reinsertion of the tracheostomy or endotracheal tube.