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 15L/min** for all patients with impending respiratory arrest/failure

3. For airway obstruction due to foreign body:
   - If patient unable to speak but is conscious, perform 5 abdominal thrusts or, if <1 year, alternate 5 back blows and 5 chest thrusts
   - If patient becomes unconscious lower to ground and begin chest compressions
   - If patient is unconscious, initiate CPR x 2 min
     - 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 EDAP and **CONTACT BASE** en route

5. Advanced airway prn for patients of appropriate age and size (*MCG 1302*)

6. Initiate cardiac monitoring (*MCG 1308*)

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

8. Consider specific presentation:
   - For suspected anaphylaxis treat per **TP 1219-P, Allergy**

   For stridor concerning for croup or tracheitis:
   - <1 year old: **Epinephrine (1mg/mL) 2.5mL via neb**, dose per *MCG 1309*<sup>2</sup>
   - ≥1 year of age: **Epinephrine (1mg/mL) 5mL via neb**, dose per *MCG 1309*<sup>2</sup>
   - Repeat x1 in 10 min prn, maximum 2 total doses prior to Base contact
   - Prepare to manage airway if patient’s condition deteriorates

   For visible airway/tongue swelling:
   - **Epinephrine (1mg/mL) 0.01mg/kg IM** dose per *MCG 1309*
   - Repeat every 10 min pm x2, maximum 3 total doses prior to Base contact

   For patients with a tracheostomy and suspected obstruction:<sup>3</sup>
   - Attempt succioning
Remove and clean inner cannula with saline; replace if positive-pressure ventilation required
If obstruction is not relieved by above maneuvers:

For children ≥ 7 years of age consider placing a 6.0mm endotracheal tube in the stoma and attempt BMV

For children < 7 years of age remove entire tracheostomy tube and cover stoma and attempt BMV first via the mouth. If no chest rise attempt BMV over stoma with a small mask.
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. Consider blow-by to avoid agitation in pediatric patients if a mask cannot be tolerated (e.g., infants and toddlers).

3. 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 usually only used during insertion. The inner cannula allows for connection to a ventilator or bag mask for positive pressure ventilation. Tracheostomy tubes may be cuffed (balloon inflated in the trachea as indicated by a side port) or uncuffed. If the tracheostomy does not have a cuff, 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 the appropriate size is available) 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.

4. 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 is relieved. If it cannot be replaced, cover the stoma with gauze and begin BMV via the mouth. If no chest rise, place a small mask over the stoma and begin stoma-mask ventilation.

5. 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.