EMS Adult Protocols

<table>
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<th>Protocol Title:</th>
<th>Medication Assisted Airway</th>
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<td>Original Adoption Date:</td>
<td>9/2000</td>
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<td>Date of Most Recent Update:</td>
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**Basic Treatment Guidelines:**
Follow initial protocol for all patients.

**Indications:**
1. An airway unable to be controlled and/or maintained by basic airway management techniques secondary to trauma or overdose when further sedation or paralyzation is needed.
2. Decreased level of consciousness, combativeness, or severe agitation secondary to trauma, suspected CVA or hypoxia.
3. Combative or uncontrollable head/multiple trauma patient that presents potential for injury to self or others allowing for further stabilization treatment
4. CHF, COPD, or Asthma patients with hypoxia and/or respiratory exhaustion
5. Burn patient with potential or existing respiratory compromise

**Precautions:**
1. **SUCCINYLCHOLINE** is absolutely contraindicated in patients with a personal or family history of malignant hyperthermia and in patients deemed to be at high risk of developing severe hyperkalemia.
2. Use of **SUCCINYLCHOLINE** is contraindicated in patients with tissue destructive conditions: crushing injuries or burns > 72 hrs old, patients with Muscular Dystrophy, pre-existing spinal cord injury resulting in paralysis, Rhabdomyolysis, or significant hyperkalemia (eg, suggested by characteristic changes on an electrocardiogram)
3. Anticipated difficult intubation or severe maxillo-facial trauma
4. Hypersensitivity to the medications used.
Preparation:
1. Establish IV of NORMAL SALINE, Cardiac Monitoring, and continuous pulse oximetry.
2. Ensure all intubation equipment is prepared to include medications drawn up, capnography, and suction.
3. Ensure a King LT-D is available as a rescue airway.
4. Ensure adequate spinal immobilization precautions
5. Preoxygenate using good basic airway technique, with high flow oxygen using OPA/NPA and mask/BVM for 1-2 minutes. Prolonged manual ventilation may result in gastric distension with vomiting and aspiration. Be prepared to suction as needed.

*Note* Endotracheal Intubation attempts shall be limited to two using a conventional laryngoscope. In the case where two unsuccessful attempts have been made, one attempt may be made using a video-laryngoscope before moving to another airway device such as the King LT. One additional attempt may be made by a supervisory staff, at their discretion if their arrival on scene follows the initial three attempts. The definition of an Endotracheal Intubation attempt is “Anytime direct laryngoscopy is made with the intent to place the endotracheal tube.”

Procedure:
1. Administer KETAMINE 2.0 mg/kg IV to render patient into an unconscious state (KETAMINE will not remove the patients gag reflex. Maintain suction equipment at a ready state).

2. Administer SUCCINYLCHOLINE 1.5 mg/kg. Wait approximately 60 – 90 seconds after administration, or after fasciculations and flaccid muscle tone are observed to proceed with intubation.

3. Once intubation is completed, confirm the tube placement, secure the tube, and apply capnography. If bradycardia occurs associated with intubation, temporarily hold attempt and oxygenate the patient with BVM and 100% oxygen. If the patient remains bradycardic, consider ATROPINE 0.5 mg IV.

If intubation is successful:
Once ETT placement is confirmed by waveform capnography, continue sedation as needed with KETAMINE 1.0 mg/kg when there is no suspicion of intracranial hemorrhage or dissecting aneurysm or MIDAZOLAM IV in 2-5 mg. increments until desired effect, maintaining a systolic blood pressure above 100 mm/hg.

Post Intubation Checklist:
- Confirm ET tube placement with:
  - Primary: Capnography
  - Secondary: Epigastric and lung sounds auscultation, fogging of ETT and chest rise.
After intubation, monitor the patient with ETCO2 to ensure proper ventilation and endotracheal tube placement.
Special considerations:
Consider other options such as BVM, Needle Cricothyrotomy, or KING LT-D.