ORAL ENDOTRACHEAL INTUBATION PROCEDURE

Indications

• Severe ventilatory compromise where the airway cannot be adequately maintained by BLS techniques

Procedure preparation

• Open airway and pre-oxygenate with BVM for 1-3 minutes with 100% O2
• Avoid hyperventilation in cardiac arrest
• Select proper sized ETT and insert stylet
• Select proper sized laryngoscope blade and visualize larynx
• Suction as needed

Procedure

• Provide continuous high flow oxygen during procedure, if possible
• Under direct visualization, insert ETT 2-3cm past the cords.
• Each attempt should not exceed 30 seconds, hyperventilating between attempts
• Remove stylet and inflate cuff

• Verify placement using all of the following:
  • Rise and fall of chest
  • Absence of epigastric sounds
  • Bilateral breath sounds
  • Presence of condensation in the tube
  • EDD or colorimetric CO2 device
  • Capnometry/capnography
  • Secure the tube. Consider spinal immobilization to prevent extubation
  • Reassess tube placement after each movement.
  • If any doubt about placement, confirm by capnography or direct visualization

Equipment

• Battery powered laryngoscope handle and blades, extra batteries and bulbs
• Video Laryngoscope (if available)
• McGill forceps
• Cuffed endotracheal tubes
• ETTI
• Lubricating jelly
• Disposable stylets
• Suction
• Pulse oximetry
• End Tidal CO2 detector
• Esophageal Detector Device (EDD)
• Colorimetric CO2 device
• Capnometer or capnography

SPECIAL CONSIDERATIONS

• Defibrillation should precede intubation in VF/pulseless VT
• Consider use of ETTI if difficult intubation
• If unsuccessful after 1 attempt, may attempt King tube or iGel x1. If unsuccessful with King tube or iGel, then manage with BLS airway

Critical Information

• Absolute contraindications:
  • Patient fits on length based tape
  • Epiglottitis
• Relative contraindications:
  • Spontaneous respirations are present
  • Responsive patient with intact gag reflex
  • Suspected opiate overdose
  • Profound hypoglycemia