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