**Pediatric Airway**

**Basic maneuvers first**
- Open airway chin lift/jaw thrust
- Nasal or oral airway
- Bag-valve mask (BVM)

If indicated:
- Spinal motion restriction

**E**

Airway foreign body obstruction procedure

No

Complete obstruction?

Yes

Abdominal thrusts (conscious)
Chest compression (unconscious)

No

Breathing/oxygenation support required?

Yes

Monitor/reassess supplemental oxygen
If indicated

Exit to appropriate TG

No

Airway patent?

Yes

Supplemental oxygen via BVM

**P**

Monitor continuous ETCO₂

**E**

Supplement oxygen
Goal oxygen saturation ≥ 94%

Exit to appropriate TG

**No**

Notify receiving facility.
Contact Base Hospital for medical direction

If an attempt fails, reassess and approach with a different technique.

The maximum allowed attempts for an advanced airway placement is two (2).

**Reassess airway procedure and adjust if necessary**

**For patients > 4ft and > 40kg in cardiac arrest**
Place King Airway as appropriate

**For patients > 40kg**
Intubate with ETT as appropriate

**For patients > 4ft and > 40kg**
Place King Airway as appropriate

**Consider, sedation if King Airway or ETT in place**
Midazolam IV/IM/IO
Use Pediatape and refer to dosing guide

**Notify receiving facility.**
Contact Base Hospital for medical direction
Pearls

• Placement of an advanced airway is not a priority during the first five minutes of resuscitation unless ventilation is unable to be maintained with basic maneuvers.
• Advanced airways are only approved for patients over 40kg. A height of > 4ft is also required for the King Airway.
• Capnometry is mandatory with all methods of airway management. Document results.
• Continuous capnometry (EtCO₂) is mandatory for the monitoring of all respiratory patients.
• If an effective airway is being maintained with a BVM and a basic airway adjunct with continuous pulse oximetry values of ≥ 90% or values expected based on pathophysiologic condition with otherwise reassuring vital sign (e.g. pulse oximetry of 85% with otherwise normal vital signs in a post-drowning patient), it is expected to continue with basic airway measures.
• For the purposes of this TG, a secure airway is achieved when the patient is receiving appropriate oxygenation and ventilation.
• An intubation attempt is defined as passing the laryngoscope blade or advanced airway past the teeth with the intent to intubate.
• An appropriate ventilatory rate is one that maintains an EtCO₂ of 35 or greater. Avoid hyperventilation.
• Patients with perfusing pulses should be managed with a BLS airway unless unable to successfully ventilate.

• Contraindications for King Airway:
  • Presence of gag reflex
  • Caustic ingestion
  • Known esophageal disease
  • Laryngectomy with stoma (alternatively place ET in stoma)
  • Height < 4ft

• Effective use of a BVM requires two (2) people.
• Airway is a more important intervention in pediatric arrests. This should be accomplished quickly with a BVM and appropriately sized mask. Patient survival is often dependent on proper ventilation and oxygenation.
• Maintain spinal immobilization for patients with suspected spinal injury.
• Hyperventilation in deteriorating head trauma should only be done to maintain an EtCO₂ of 30-35.
• It is important to secure the advanced airway well and consider c-collar (in the absence of trauma) to better maintain advanced airway placement. Manual stabilization of advanced airway should be used during all patient moves/transfers.