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 Executive Director

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 Medical Director

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PEDIATRIC AIRWAY OBSTRUCTION

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

Transport patient immediately to the closest receiving hospital if unable to clear obstruction or otherwise establish an airway. All patients should be transported to a receiving hospital regardless of airway maneuvers.

Needle Cricothyrotomy is contraindicated in pediatric patients.

STANDING ORDERS	
STABLE	
ABCs	
OXYGEN	
MONITOR	Treat rhythm as appropriate.
SEVERE OBSTRUCTION – unable to cough or speak	
CONSIDER CAUSE	
• Foreign body:	Abdominal thrusts, finger sweep, laryngoscopy and removal with Magill Forceps
• Croup/Epiglottitis:	Position of comfort. Consider humidified or nebulized oxygen with the highest flow rate tolerated. Avoid visualization of throat unless tracheal intubation required. Refer to Policy 555.23 Respiratory Distress
• Trauma:	Intubate and suction.
• Anaphylaxis:	Refer to Allergic Reaction Policy 555.42.
DIRECT AIRWAY VISUALIZATION	with laryngoscope and oral intubation, if patient unable to maintain airway. Confirm placement with end-tidal CO ₂ detector and esophageal detector device. Continuous waveform capnography should be used in all intubated patients, if available.
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