**History**
- Sudden onset of shortness of breath/coughing
- Past medical history
- Sudden loss of speech
- Syncope
- COPD/Asthma
- CHF
- Cardiac disease
- Lung disease

**Signs and Symptoms**
- Sudden onset of coughing, wheezing or gagging
- Stridor
- Inability to talk in complete sentences
- Panic
- Pointing to throat
- Syncope
- Cyanosis

**Differential**
- Foreign body aspiration
- Seizure
- Epiglottitis
- Syncope
- Hypoxia
- Asthma/COPD
- CHF exacerbation
- Anaphylaxis
- Massive pulmonary embolus

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**EMT**
Use i-gel airway only when unable to adequately ventilate with a BVM and OPA or when ALS arrival is > 10 min after BLS arrival.

**PARAMEDIC**
The maximum attempts allowed for an advanced airway placement is three (3) per patient (2 video and 1 direct). If an attempt fails, reassess and approach with a different technique.

ETT must be attempted three (3) times prior to placement of i-gel airway.

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**Flowchart Diagram**

1. Is airway/breathing adequate?
   - Yes: Exit to Routine Medical Care
   - No: Basic airway maneuvers
     - Open airway with chin lift/jaw thrust
     - Nasal or oral airway
     - BVM
   - SpO2 monitoring
   - Supplemental oxygen to maintain SpO2 ≥ 92%
   - Spinal motion restriction if indicated

2. Airway patent?
   - Yes: BVM with supplemental oxygen to maintain SpO2 ≥ 92%
   - No: Complete obstruction?
     - Yes: Airway Foreign Body Removal
     - No: BVM effective?
       - Yes: Continue BVM
       - No: Consider, i-gel airway
         - Advanced airway with video laryngoscopy
         - Advanced airway with direct laryngoscopy

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**For cause known, exit to appropriate protocol**

**Notify receiving facility. Consider Base Hospital for medical direction**
San Mateo County Emergency Medical Services

Respiratory Arrest/Respiratory Failure

For patients requiring positive-pressure ventilation and/or hypoxia despite 100% oxygen

Pearls

• Effective use of a BVM is best achieved with two (2) providers. Use adult BVM until cardiac arrest.

• Continuous capnometry (EtCO₂) is mandatory with all intubations and BVM. Document results.

• 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 acceptable to continue with basic airway measures rather than placing an advanced airway.

• If after placement, an i-gel device is ineffective, attempt to reposition the device. If it remains ineffective, remove the device.

• 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 to 45.

• The airway should be reassessed with each patient move. Document findings and EtCO₂ readings for each.

• Maintain spinal motion restriction for patients with suspected spinal injury.

• In deteriorating patients with head trauma, increase ventilation rate to maintain an EtCO₂ of 30-35.

• It is important to secure the advanced airway well and consider c-collar use (in the absence of trauma) to better maintain advanced airway placement. Manual stabilization of advanced airway should be used during all patient moves/transfers.