TITLE: AIRWAY MAINTENANCE IN TRAUMA

PURPOSE:

Is to achieve and maintain a patent airway and adequate oxygenation and to anticipate the need for additional airway adjuncts.

PROCESS:

1. AIRWAY MAINTENANCE
   A. The primary survey as described in Advanced Trauma Life Support (ATLS) provides a simple organized approach to airway maintenance in trauma patients and should be used as a guideline for resuscitation of trauma patients.
   B. Perform airway/breathing assessment while maintaining cervical immobilization when appropriate. Assess the neck for gross deformity and pain with palpation. Check all extremities for movement, sensation and pulses. Patients requiring airway management include:
      1. Apnea
      2. Airway obstruction unresponsive to basic control maneuvers
      3. Respiratory distress
      4. Severe maxillofacial trauma
      5. Profound circulatory collapse
      6. Altered mental status-Glasgow Coma Scale (GCS) <8

NOTE: The airway/breathing assessment with appropriate intervention and stabilization must be performed prior to continuing patient care. Further assessment, intervention and therapy are based upon the concept that appropriate attention and management has been provided for the patient's airway/breathing.
Guidelines and Protocols

C. Perform basic airway maneuvers such as providing supplemental oxygen by facemask, and use of a chin lift/jaw thrust (no head tilt) to provide an open airway. If the cervical spine status in unknown, a chin lift is preferred.

D. If unable to maintain an adequate airway, perform tracheal intubation. Orotracheal intubation is the preferred method for apneic trauma patients. Maintain C-spine alignment when appropriate.

E. Nasotracheal intubation is preferred method when the patient is still breathing; however, it is contraindicated in cases of severe maxillofacial trauma, coagulopathy, or signs of basilar skull fracture (radiologic evidence, hemotypanum, “raccoon eyes”, or Battle signs).

F. Endotracheal intubation maybe performed by EC residents under direct observation of an EC Faculty.

G. If EC resident is unsuccessful, subsequent second endotracheal intubation must be performed by EC Faculty, General Surgery Attending and or Anesthesia Faculty.

H. In patients with unsuccessful intubation a surgical airway shall be performed.

I. A surgical airway should always be considered in patients with a difficult airway and not used as a "last resort".

J. Document all airway/breathing assessments and interventions on the appropriate EC medical record. Documentation must include all medications given, number of attempts at intubation, equipment used and description of the glottis grade.

K. Assure that the time in which the consultation was initiated, the time in which the consulting service replied, and arrival times are documented in the appropriate EC medical record.
Guidelines and Protocols

REFERENCE / BIBLIOGRAPHY:


OFFICE OF PRIMARY RESPONSIBILITY:

LYNDON B. JOHNSON HOSPITAL TRAUMA SERVICES

REVIEW / REVISION HISTORY

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