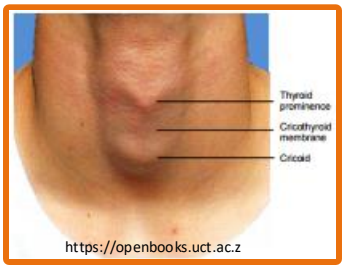
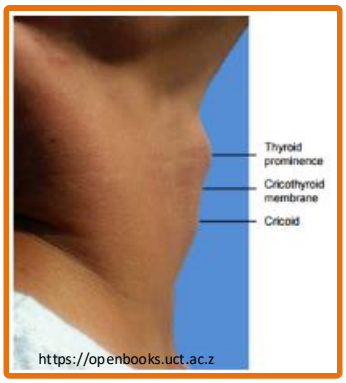
Cricothyrotomy

Paramedics MUST have written approval from their EMS FTO/Medical Director before using this protocol.

When able, cricothryotomy should be formed by the qualified ALS provider that did NOT last attempt to intubate



- Team Leader says out loud to the team **"This is a Can't Oxygenate|Can't Intubate patient"** to ensure team moves toward SGA and preparation for cricothyroidotomy
- Team Leader confirms that ventilation is inadequate despite BVM and SGA (or SGA insertion is not possible due to upper airway obstruction)



- Remove pillows/blankets from under patient s head and neck
- Hyperextend patient s neck
- Palpate landmarks and identify cricothyroid membrane[1,2]

Perform surgical or large bore needle cricothyrotomy[3,4]
Utilize Control –Quik Trach Kit if available

The agency Medical Director should be notified immediately upon completion of patient care whenever cricothyrotomy is performed

Trachea successfully intubated?

No → If needle cricothyrotomy was originally performed, provider may consider attempting surgical cricothyrotomy if previously trained and approved by their agency s Medical Director

Yes

Secure ETT or cannula with neck tape

Reconfirm placement by using continuous $ETCO_2$ capnography

Proceed to **Airway Management 3 of 3: Post-Intubation Airway Management Protocol**

[1] The thyroid prominence (aka Adam s apple) is more evident and easily palpated on some individuals than others. When one cannot easily find this landmark, the provider should use the laryngeal handshake method to palpate the entire laryngeal framework (thyroid + cricoid cartilage) instead of palpating with just the tips of their index fingers. With the laryngeal handshake method, the provider uses their whole hand to move the thyroid and cricoid cartilages side to side.

[2] If unable to palpate landmarks, providers performing a surgical cric should consider first making a vertical incision through the skin and dissecting with fingers on both hands to identify and stabilize the larynx prior to puncturing the cricothyroid membrane.

[3] Choice of needle versus surgical cricothyrotomy use should be determined in advance by the agency s Medical Director. Narrow bore or small cannula needle cricothryotomy (e.g. 12 or 14 g catheters with jet insufflation) is not recommended; however, large bore needles and catheters (4mm diameter or greater) allow for sufficient emergency oxygenation and ventilation. **Providers should not perform surgical cricothyrotomy on children less than 12 years of age.**

[4] Providers performing surgical cricothyrotomy should consider inserting a Bougie (similar to endotracheal intubation) to assist with proper tube placement.