



Approach to Emergent Airway Management

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1. Oxygenation

- Better pre-oxygenation = more apneic time = easier intubation
- Prolonged hypoxia during intubation -> cardiac arrest
- Sick, dying, crash airway -> BVM with PEEP
- Standard pre-oxygenation -> Nasal Cannula (NC) and Non-Rebreather (NRB)
- Difficult pre-oxygenation -> CPAP/BiPAP



2. Hemodynamic Stabilization

- Hypotension during intubation -> cardiac arrest
- Stabilize BP prior to intubation with fluids, peripheral vasopressors



3. Prep

- S: suction
- O: oxygen (BVM, NC, NRB, oral/nasal airways)
- A: airway (ET tubes, MAC/Miller blades, glidescope, bougie, scalpel)
- P: Pharm (paralytic, sedative)



4. Plan

- 1st attempt: DL, VL
- 2nd attempt: DL w/ bougie, VL
- 3rd: VL, new operator
- In between attempts, consider re-oxygenating/pre-oxygenating with BVM
- Can't intubate: must oxygenate: BVM w/ PEEP, LMA
- Can't intubate, can't ventilate (aka: can't oxygenate): always be prepared to perform a surgical airway



5. Post Intubation

- Confirm ET placement: ETCO₂, breath sounds, XR chest
- Analgesia/Sedation: fentanyl gtt, propofol gtt
- Vent Settings: ARDSnet protocol, match pre-intubation minute ventilation via ventilator respiratory rate to avoid worsening acidosis