RSI Protocol

1. Preparation
   - Cardiac monitor, pulse oximetry, IV access
   - ACLS drugs
   - BVM, suction, end-tidal CO_2 detector
   - Test ETT and equipment
   - Difficult airway bag (with LMA), cricothyrotomy tray and scalpel
2. Difficult airway anticipated (e.g. halo)?
   - Consider awake intubation, fiber-optic etc. Review Difficult Airway Algorithm.
3. Preoxygenation
4. Positioning
   - Remove collar
   - Stabilize cervical spine
   - Sellick Maneuver
5. Traumatic Brain Injury:
   - Lidocaine 1.5 mg/kg 3 minutes prior to intubation (100 mg)
6. Induction Agent

DRUG	DOSAGE	ONSET	DURATION	INDICATIONS	CAUTIONS
Etomidate	Stable: 0.3 mg/kg Unstable: 0.15 mg/kg	30-60 s	3-5 m	Multitrauma, hypotension	Inhibits cortisol synthesis; decreases focal seizure threshold

7. Neuromuscular Blocking Agent

Drug	Dosage	Onset	Duration	Indications	Cautions
Succinylcholine	1.5 mg/kg	30-60 s	5-15 m	Default agent in the absence of contraindications	Personal or family history of MH, hyperkalemia, myopathy, chronic neuropathy/stroke, denervation illness or injury after 3 days, crush injury after 3 days, sepsis after 7 days, severe burns after 24 h
Rocuronium	1 mg/kg	45-60 s	45-70 m	When succinylcholine is contraindicated	Predicted difficult intubation and ventilation; allergy to aminosteroid NMBA

8. Intubate
9. Confirm placement and secure ETT
    a. End-Tidal Co2
    b. Auscultation in axillae for bilateral breath sounds, epigastrium
10. Sedation orders
11. Ventilator settings
12. CXR

References

1. Reynolds SF, Heffner J. Airway Management of the Critically Ill Patient: Rapid-Sequence Intubation. Chest 2005; 127: 1397-1412.
2. ASA Taskforce on Management of the Difficult Airway. Practice Management Guidelines for Management of the Difficult Airway. Anesthesiology 2003; 98: 1269-77.

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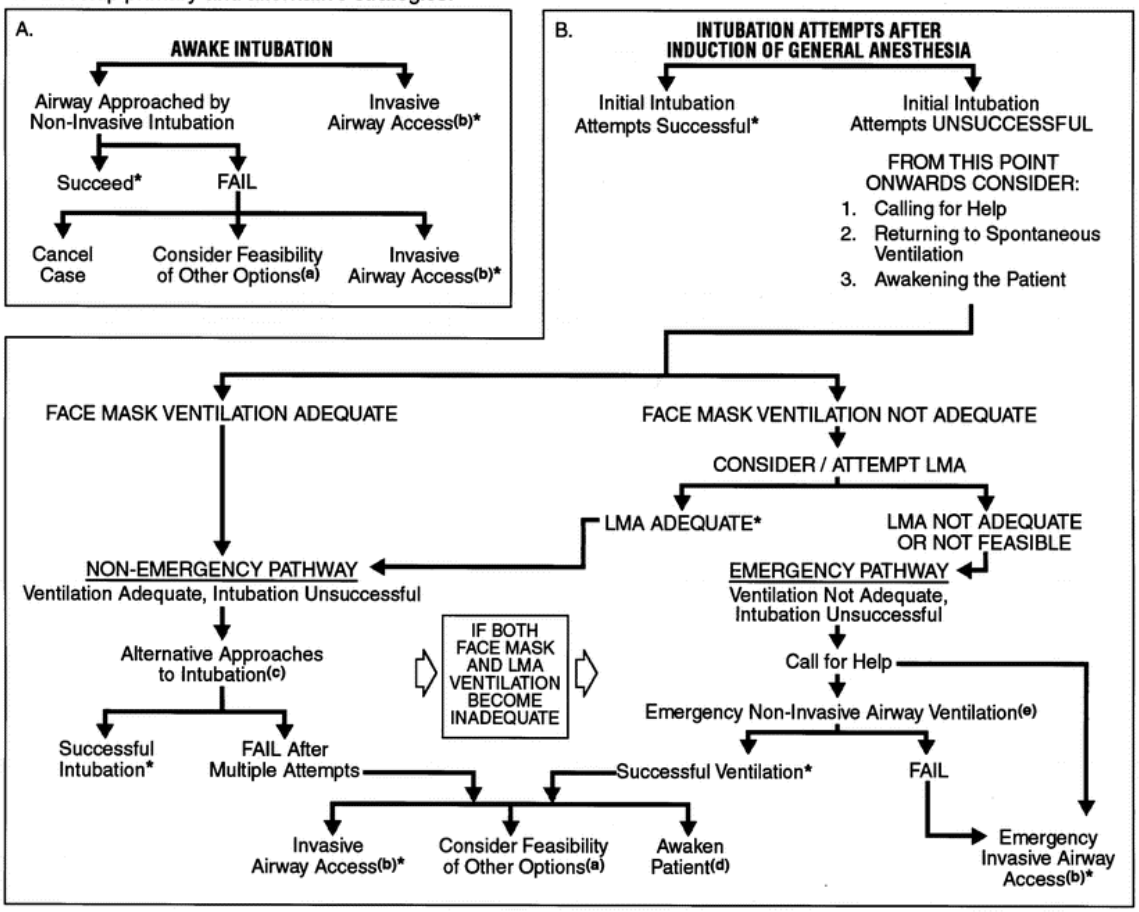
DIFFICULT AIRWAY ALGORITHM

1. Assess the likelihood and clinical impact of basic management problems:
   - A. Difficult Ventilation
   - B. Difficult Intubation
   - C. Difficulty with Patient Cooperation or Consent
   - D. Difficult Tracheostomy
2. Actively pursue opportunities to deliver supplemental oxygen throughout the process of difficult airway management
3. Consider the relative merits and feasibility of basic management choices:

A.	Awake Intubation	vs.	Intubation Attempts After Induction of General Anesthesia
B.	Non-Invasive Technique for Initial Approach to Intubation	vs.	Invasive Technique for Initial Approach to Intubation
C.	Preservation of Spontaneous Ventilation	vs.	Ablation of Spontaneous Ventilation

4. Develop primary and alternative strategies:



*** Confirm ventilation, tracheal intubation, or LMA placement with exhaled CO_2**

a. Other options include (but are not limited to): surgery utilizing face mask or LMA anesthesia, local anesthesia infiltration or regional nerve blockade. Pursuit of these options usually implies that mask ventilation will not be problematic. Therefore, these options may be of limited value if this step in the algorithm has been reached via the Emergency Pathway.

b. Invasive airway access includes surgical or percutaneous tracheostomy or cricothyrotomy.

c. Alternative non-invasive approaches to difficult intubation include (but are not limited to): use of different laryngoscope blades, LMA as an intubation conduit (with or without fiberoptic guidance), fiberoptic intubation, intubating stylet or tube changer, light wand, retrograde intubation, and blind oral or nasal intubation.

d. Consider re-preparation of the patient for awake intubation or canceling surgery.

e. Options for emergency non-invasive airway ventilation include (but are not limited to): rigid bronchoscope, esophageal-tracheal combitube ventilation, or transtracheal jet ventilation.