Indications:

1. Orotracheal intubation provides definitive control of the airway and prevents aspiration.

Precautions:

1. Orotracheal intubation should be performed carefully, with head and neck stabilized, when there is a risk for c-spine injuries.
2. The jaw should be lifted with direct upward traction on the laryngoscope. Be careful not to lever the laryngoscope blade against the teeth.
3. Suction must be ready. Regurgitation into the tube can occur, especially when the esophagus is entered and then the contaminated tube must be replaced.
4. Proper positioning of head and body of both the pt and the medic is often critical to a successful orotracheal intubation.

Technique:

1. Assemble the equipment while continuing ventilation.
2. Preoxygenate patient. Remove loose dentures if present.
3. Premedicate the patient as needed for RSI, for ICP reduction, for emesis reduction; unless the patient is in cardiac arrest.
4. Position the patient. If no risk of c-spine injury, the neck can be flexed forward and the head extended back. Back of head should be level with or slightly higher than back of shoulders.
5. Insert laryngoscope. Have an assistant apply gentle cricothyroid pressure (Sellick maneuver). This will assist in preventing aspiration as well as facilitate visualization of the vocal cords.
6. Once vocal cords are identified, insert endotracheal tube passed the cords into the trachea.
7. Advance tube so cuff is 1-1.5 inches beyond cords. This will typically be 19-21 cm at the teeth for adults.
8. Listen for breath sounds on both sides of the chest and, if present, inflate the cuff balloon with 5 to 10 cc's of air.
9. To further verify endotracheal tube placement, listen over the stomach, watch for chest rise with ventilation, and use end tidal CO_2 detector.

10. Note position of the endotracheal tube and secure in place.
11. If you have not already done so, consider immobilizing the head including use of a c-collar to prevent tube dislodgment.
12. Re-auscultate over stomach and both sides of chest whenever the patient is moved. Continue to monitor ETCO2.
13. If ETCO2 rises, SAO2 declines, or bagging becomes difficult, consider the following causes. Check for tube dislodgment. Check for tube obstruction such as by clot or edema fluid. Check for tension pneumothorax. Check for worsening lung conditions such as wheezes or rales. Treat those conditions that are found.

Notes

1. In a patient where intubation is indicated, but you believe that successful intubation is unlikely, consider a King Tube.