Jackson Hole Fire/EMS Operations Manual

Approved by: _____
Will Smith, MD, Medical Director

Approved by: _____ 12/9/19
Brady Hansen, Chief

Title: **Procedure Guidelines: i-gel Supraglottic Airway**
Division: 17
Article: 2.5
Revised: December 2019
Pages: 2

i-gel® Supraglottic Airway
(Procedure Guidelines)

SCOPE OF PRACTICE

All EMT-Intermediates and Paramedics shall operate within their authorized Scope of Practice as limited to those skills and medication approved for use by the Physician Medical Director and as approved and authorized by the Wyoming Board of Medicine

SCOPE OF PRACTICE:

EMT-Intermediate, Paramedic

INDICATIONS:

Patients in cardiac, respiratory arrest, or in need of advanced airway control that cannot be maintained by BLS maneuvers.
It is also suitable as a backup airway for failed endotracheal intubation attempts.

CONTRAINDICATIONS:

- Responsive patients with an intact gag reflex
- Patient with any condition which may increase the risk of a full stomach e.g. hiatus hernia, sepsis, morbid obesity, pregnancy or a history of upper gastro-intestinal surgery etc.

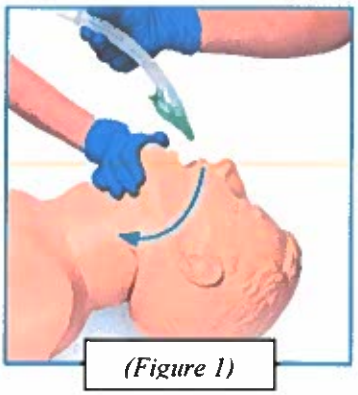
PRECAUTIONS:

- The i-gel must be lubricated for use and do not use excessive force
- Do not leave the device in place for more than four hours
- Do not allow peak airway pressure of ventilation to exceed 40cm H_20
- Excessive air leak during manual ventilation is primarily due to sub-optimal depth of i-gel insertion

INSERTION INSTRUCTIONS:

- Select the correct i-gel Supraglottic Airway size based on patient weight.
- Ensure that gag reflex is not intact.
- Lubricate the back, sides and front of the cuff with a thin layer of lubricant.

- Grasp the i-gel firmly along the integral bite block. Position the device so that the i-gel cuff outlet is facing towards the chin of the patient *(Figure 1)*.
- The patient should be in the 'sniffing the morning air' position *(Figure 1)* with head extended and neck flexed unless head/neck movements are contraindicated. The chin should be gently pressed down before proceeding to insert the i-gel.
- Introduce the leading soft tip into the mouth of the patient in a direction towards the hard palate.
- Glide the device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt.



(Figure 1)

- At this point the tip of the airway should be located into the upper esophageal opening and the cuff should be located against the laryngeal framework. The incisors should be resting on the integral bite-block.
- Sometimes a feel of 'give-way' is felt before the end point resistance is met. This is due to the passage of the bowl of the i-gel through the faucial pillars (pharyngo-epiglottic folds).
- A horizontal line (adult sizes 3, 4 and 5 only) at the middle of the integral bite-block represents the correct position of the teeth.
- Attach BVM.
- Confirm proper position by auscultation, chest movement, and verification of $ETCO_2$ by capnography
- The i-gel should be held in place until secured
- If required, an appropriate size nasogastric tube may be passed down the gastric channel
- Continue to monitor

PROPER SIZING OF THE i-gel:

Size selection on a weight basis should be applicable to the majority of patients, individual anatomical variations mean the weight guidance provided should always be considered in conjunction with a clinical assessment of the patient's anatomy.

Patients with central obesity, might in practice require an i-gel of a size commensurate with the ideal body weight for their height rather than their actual body weight.

i-gel size	Patient Size	Patient weight guidance (kg)
1	Neonate	2-5kg
1.5	Infant	5-12kg
2	Small paediatric	10-25kg
2.5	Large paediatric	25-35kg
3	Small adult	30-60kg
4	Medium adult	50-90kg
5	Large adult	90+kg

i-gel size	Maximum size of Nasogastric Tube (FG)
1	N/A
1.5	10
2	12
2.5	12
3	12
4	12
5	14