



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

AIRWAY MANAGEMENT TASK FORCE

March 2, 2011--09:00 A.M.

MEMBERS PRESENT

K. Alexander Malone, MD, Chairman, NLVFD
Chief Scott Vivier, Henderson Fire Department
Bryan Bledsoe, DO, MedicWest Ambulance
Chad Henry, EMT-P, American Medical Response
Richard Henderson, MD, Henderson Fire Department

Michele McKee, MD, UMC Hospital
Chief Troy Tuke, Clark County Fire Department
Scott Scherr, MD, Sunrise Hospital
Nancy Cassell, College of Southern Nevada

MEMBERS ABSENT

Chief Bruce Evans, North Las Vegas Fire Dept

Derek Cox, Las Vegas Fire & Rescue

SNHD STAFF PRESENT

Rory Chetelat, EMS Manager
John Hammond, EMSTS Field Rep
Judy Tabat, Recording Secretary

Mary Ellen Britt, Regional Trauma Coordinator
Trish Beckwith, EMSTS Field Rep

PUBLIC ATTENDANCE

Steve Patraw, BoundTree
Trish Klein, NCTI
Richard Main, NCTI
Joyce Faltys, Spring Valley Hospital
Spencer Meier, Touro
Philis Beilfus

Eric Dievendorf, American Medical Response
Victor Quon, TriStar CareFlight
Brian Rogers, Henderson Fire Department
Pat Elkins, Spring Valley Hospital
Mark Calabrese, MedicWest Ambulance

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Airway Management Task Force convened in the Clemens Conference Room at the Ravenholt Public Health Center at 9:05 a.m. on Wednesday, March 2, 2011. The meeting was called to order by Chairman Alex Malone, MD. He stated that the Affidavit of Posting, Mailing of Agenda, and Public Notice of the Meeting Agenda were executed in accordance with the Nevada Open Meeting Law. Chairman Malone noted that a quorum was present.

I. CONSENT AGENDA

Chairman Malone stated the Consent Agenda consisted of matters to be considered by the Airway Management Task Force that can be enacted by one motion. Any item may be discussed separately per Task Force member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Minutes Airway Management Task Force Meeting March 5, 2003

Chairman Malone asked for a motion to approve the minutes of the March 5, 2003 Airway Management Task Force meeting. A motion to accept the minutes was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

Dr. Malone started off the discussion by promising to keep these meetings quick and succinct and felt that if there are people that are knowledgeable in the matter at hand with good evidenced based practice and ideas behind it, this Task Force should be able to move forward in the interest of progress. He then did a power point presentation on the history of airway management from 1500 B.C. to current day.

Dr. Malone reviewed what the future objectives will be with the reinstatement of this Task Force.

- What are our priorities?
- What are some current controversies that we face locally
 - NIV (non-invasive ventilation)
 - Extraglottic Airways
 - RSI (rapid sequence intubation)
 - Surgical Airways
 - Needle cricothyroidotomy
- Pediatric airway management

Discussion of Revisions to Airway Bundle

General Patient Care (GPC)

D3. Breathing – Chief Vivier stated that Dr. Henderson was given the assignment of rewriting this language in the last Drug/Device/Protocol Committee meeting and presented a draft of the changes. The recommendations were:

- Strike: 2a: “12-15 lpm NRB to all patients (including COPD) experiencing cardiovascular, respiratory, or neurological compromise.”
- Strike: 2b: “2-6 lpm by nasal cannula or 6-15 lpm mask delivery device to ALL other patients with no history of prescribed home oxygen.”
- Add 2c: “or an amount sufficient to provide for a SPO2 >90%”
- Add 3: “Oxygen treatment should be titrated to maintain a SPO2 >94%”

A motion was made to accept the revisions to the General Patient Card protocol. The motion was seconded and passed unanimously.

Advanced Airway Management

Dr. Malone stated that the last revision to this protocol was on the medications. Dr. Bledsoe commented that pharmacologically speaking, intubation has been problematic everywhere unless a blockade is used. Dr. Malone agreed but wasn't optimistic sweeping changes would result. He added as an educational note, one thing that has been mentioned in the past is confirming tracheal placement and how that is being done. It's a reminder that providers in the pre hospital environment want to add some of the things listed under tube depth inadequacy under confirmation and he felt that it is important to keep tube depth inadequacy and confirming tracheal placement separate.

Dr. Bledsoe stated that taking that into consideration he felt you can't make that argument in pediatric medication facilitated intubation and added that pediatric patients shouldn't be intubated.

Dr. McKee agreed and stated that bag valve mask (BVM) is the way to go and felt that pediatric intubation would fit better in another section of this protocol. She added that there has been discussion in the past about letting BVM stay for the pediatric population versus advanced airway.

Dr. Malone agreed and felt that a subsection devoted to pediatric advanced airway management should be created and add it as an agenda item to next month's meeting. Chief Vivier stated that a study on pediatric airway was done previously and would like to review the minutes from those meetings.

Chief Tuke voiced concern over removing a skill set and felt that a better protocol should be determined. The Task Force agreed.

A motion was made to add "Discussion to Create a Separate Pediatric Advanced Airway Algorithm or Protocol" as an action item to next month's meeting agenda. The motion was seconded and passed unanimously.

Chief Tuke opened the discussion with regards to exploring the Pertrach device so the medics can actually ventilate the patient. Mr. Chetelat suggested bringing this back for discussion to allow somebody to do some research. Dr. Malone stated that the Committee appreciates Chief Tukes' willingness to look into the Pertrach device and then asked if this Task Force is willing to discuss prehospital surgical cricothyroidotomy. Chief Tuke stated that it is hard enough in a controlled environment to do a surgical cricothyroidotomy where the Pertrach is taking the knife out of the equation and it is safer and easier. Dr. Malone asked the Task Force if everyone is opposed to the development of a surgical cricothyroidotomy. The Task Force answered in the affirmative.

Endotracheal Intubation

Dr. Malone stated that there are 3 reasons for emergency airway intervention: Inability to adequately oxygenate and/or ventilate, inability to protect the airway, and prediction of clinical course and would like to suggest incorporating that verbiage in the protocol. He felt it would allow more freedom in the hands of the prehospital provider to make that judgment call at the scene and act in the best interest of the patient and yet doesn't provide them with too much latitude to be intubating everybody. Dr. Scherr felt that prediction of clinical course is a huge gray area. Dr. Malone agreed but added it is whatever you see at the scene that makes you think the patient is going to get worse. Dr. Bledsoe stated the other side of the argument is the studies show that intubation worsen outcomes. Dr. Malone stated that this discussion can be revisited at a later time.

Dr. Bledsoe questioned the role in modern emergency medicine for nasotracheal intubation. Chief Vivier stated that they have had 9 total nasotracheal intubations for the year 2010 with 1 successful and internally they are having discussion about removing this skill as an administrative directive out of their department because it is used too infrequently with a high margin of error and cost associated with it. Dr. Malone stated that with the advent of the modern RSI sedation and paralysis, it really has eliminated the need for nasotracheal intubation in most settings. Mr. Chetelat questioned the possibility of seeing how many are being done successfully system wide. Dr. Bledsoe stated he would be willing to work with Chief Vivier and Chief Tuke to come back with some more information.

Chief Tuke proposed that they look at adding RSI in the field. He felt that if they are talking about getting rid of nasotracheal intubations based on the fact that they now have facilitated intubations, they need to look at it and make a decision instead of going half way with partially facilitated intubation. Dr. Scherr stated that there isn't any evidence that shows greater success with just etomidate or versed with a paralytic but stated there is evidence that shows RSI in the field is not where it needs to be yet. Dr. Bledsoe disagreed stating that the numbers are pretty good in systems like Seattle and the flight medicine programs where they are doing RSI in the field. He added that he agreed with Chief Tuke and stated that its either you do or you don't and felt that he would like to see it moved that way. Dr. Malone stated that he would be happy to look at that further. Dr. Scherr felt that the difference between a prehospital setting and a hospital setting is all the different adjuncts that a hospital setting has on hand, including a plan B. Dr. Malone believes that is what makes it a requirement to have something like a Pertrach because the second you add paralytics you need to be able to access the trachea below the level of the glottis. Mr. Chetelat questioned whether we will get the frequency to really maintain the skill set. Chief Tuke stated that at the end of the day you bag them, you do BLS airway, which is what we teach our EMT's. Nancy Cassell felt that this Task Force is assuming the instructors are not teaching the students how to intubate and not consistently doing continuing education on intubating. She stated that as a practicing paramedic it will be a disservice to the community if they start removing nasotracheal intubation and

pediatric airway skills. She added that if she wanted to nasally intubate she would like to have the choice to do that rather than to use RSI to intubate them. Dr. Malone stated that as a point of clarification, he was definitely not saying they are not receiving instruction in the community. He felt it is more complex as you look at efficacy, success rate, risk benefit ratio and cost. Dr. Bledsoe added that with the advent of the extra glottic airways, a lot of general anesthesia cases are being done without intubations so the number of intubations nationwide has gone down in the hospital setting.

A motion was made to move the discussion on RSI and intubation to next month's meeting. The motion was seconded and passed unanimously.

Needle Cricothyroidotomy – tabled

Supraglottic Airway Device

Mr. Chetelat asked for a recommendation regarding sizes of King Airway devices to replace the Combitube and Combitube-SA. Dr. Malone stated that there are 3 common sizes for the King Airway device that meet the range of the former Combitube sizes but if toddlers are to be considered then a range of 2 and 2.5 would be necessary.

Size 2	weight	12kg to 25kg
Size 2.5	weight	25kg to 35kg
Size 3	height	4' to 5'
Size 4	height	5' to 6'
Size 5	height	6' and above.

Chief Vivier stated as a point of clarification the laryngeal mask airway (LMA) is included as a Supraglottic airway device and they also come in various sizes.

After considerable discussion, it was decided to keep the language Combitube or equivalent which would only be used in patients 4' and above.

A motion was made to incorporate "Supraglottic Airway Device with approved sizes to accommodate patients with a height of 4' and above". The motion was seconded and passed unanimously.

Tracheostomy Tube Replacement – no changes

III. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None

IV. PUBLIC COMMENT

None

V. ADJOURNMENT

As there was no further business, Chairman Malone called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 9:55 a.m.