Clinical Practice Guidelines:
Respiratory/Airway obstruction (foreign body)

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<tr>
<th>Date</th>
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<tr>
<td>Purpose</td>
<td>To ensure consistent management of patients with Airway obstruction (foreign body).</td>
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<td>Scope</td>
<td>Applies to all QAS clinical staff.</td>
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Foreign Body Airway Obstruction (FBAO) is a life-threatening emergency for adults and paediatrics. Although FBAO is more common in the paediatric population, the mortality rate is higher for adults in the prehospital environment.\cite{1-2} Common causes of FBAO include liquid or solid foods, small inanimate objects and medication pills.

FBAO can be a partial or complete obstruction, with partial obstructions allowing either adequate or inadequate air exchange. Inadequate air exchange from severe partial or complete obstructions are managed the same way.

**Mild airway obstruction**\cite{3} is a partial obstruction with adequate air exchange characterised by:

- patients themselves will optimise position (e.g. sitting forward)
- effective cough
- crying or verbal responses present
- able to take breath before coughing
- fully responsive

Patients with adequate gas exchange and an effective cough should be given reassurance and encouraged to continue spontaneous efforts. Inappropriate interference can result in a partial obstruction becoming severe or complete.

**Severe airway obstruction**\cite{3} is a partial obstruction with inadequate air exchange or complete obstruction characterised by:

- ineffective cough
- unable to vocalise
- worsening stridor
- quiet or silent chest / unable to breath
- cyanosis
- decreasing level of consciousness

In the unconscious, apnoeic patient FBAO is recognised by inadequate airflow and poor chest rise during attempted positive pressure ventilation.\cite{4}

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### Clinical features

#### History
- clutching of the neck
- sudden dyspnoea, gagging of coughing
- history of playing with / eating small items

#### Examination
- respiratory distress with stridor, accessory muscle use, recession and paradoxical breathing
- restlessness
- cyanosis
- unconsciousness
- bradycardia

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### Risk assessment

- Severity of the foreign body airway obstruction can be assessed with cough.
- Effective cough indicates a mild obstruction.
- Nil cough indicates a severe obstruction.
If an infant: place in head down position prior to delivering back blows.

**Mild airway obstruction**
- Place patient in position of comfort
- Encourage coughing
- Provide ongoing reassurance
- Provide supportive cares

**Severe airway obstruction**
- Consider:
  - Removing obstruction under direct visualisation
  - Oxygen
  - Gentle IPPV
  - LMA/ETT
  - Appropriate resuscitation CPG

**Consider:**
- * Up to five sharp back blows
- Up to five chest thrusts
- Repeat if required
- Ensure ongoing assessment of airway and conscious state

**Conscious?**
- Y: Effective cough?
- N: Severe airway obstruction

**Effective cough?**
- Y: Conscious?
- N: Consider:

**Transport to hospital**
**Pre-notify as appropriate**

*Note: Officers are only to perform procedures for which they have received specific training and authorisation by the QAS.*