

Additional Treatment Information

- Abdominal or chest thrusts are indicated for complete airway obstructions in conscious patients. Use chest thrusts in pregnant women or the obese; these can be performed with the patient supine, and are identical to chest compressions in CPR. No evidence exists to support the superiority of chest thrusts over abdominal thrusts (or vice versa) in any population, and controversy exists among resuscitation councils as to the effectiveness of back blows in adult populations.
- Back blows may be effective in children under one year of age, and should be alternated with chest thrusts as necessary. Children over one year old should be managed with abdominal thrusts.
- When confronted with a patient who cannot be ventilated, advanced providers should begin chest compressions or abdominal thrusts while preparing for both direct laryngoscopy and a surgical airway. Under laryngoscopic visualization, foreign bodies may be removable using Magill forceps – do not attempt to blindly insert forceps into the airway. High vacuum suction, coupled with the Ducanto catheter, may help relieve some airway obstructions.
- Advanced providers should have a low threshold to perform a surgical airway in patients who cannot be ventilated effectively where the obstruction cannot be visualized or readily removed, or in cases of pathological airway obstruction that cannot be immediately reversed.
- Open cricothyrotomy is contraindicated in children under the age of 12. In these patients, needle cricothyrotomy can be performed instead.

Referral Information

- Paramedics should be aware that abdominal thrusts have the potential to cause significant trauma, including lacerations of internal organs. Patients who received abdominal thrusts, whether from health care providers or lay rescuers, should be transported for observation and evaluation.
- Patients with resolved partial airway obstructions, who are no longer symptomatic and are not experiencing any distress, may be left at home in consultation with ClinCall.
- Pathological airway obstructions must be transported for evaluation and treatment.

General Information

- In adults, eating is the most common precipitating event in a foreign body airway obstruction, with meat being the most likely culprit. Children, by contrast, are more prone to have non-food foreign bodies.
- Submersion or drowning victims do not, as a general rule, experience airway obstructions. The use of abdominal thrusts is not recommended for these patients; the focus should be on the initiation of chest compressions as early as possible for those who are unresponsive and pulseless, and effective bag-valve mask ventilation to address the underlying hypoxia. Patients who are conscious and breathing spontaneously may benefit from CPAP use.

Interventions

First Responder

- Position patient for optimal intervention
- For partial airway obstruction: encourage patient to cough
- For complete airway obstruction **in conscious patients**: begin abdominal thrusts
 - In children under 1 year of age, administer alternating sequence of five back blows and five chest compressions until the obstruction clears or the patient becomes unconscious.
- For complete airway obstruction **in unconscious patients**: begin chest compressions
 - → [PR06: High Performance CPR](#)
- Visualize oropharynx prior to every attempt at ventilation. Remove foreign bodies if seen. Do not attempt blind finger sweeps.

Emergency Medical Responder – All FR interventions, plus:

- Initiate transport with notification

- Consider ACP/CCP intercept

Primary Care Paramedic – All FR and EMR interventions, plus:

- Initiate transport with notification
- Consider ACP/CCP intercept

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

- As above, plus:
 - Consider direct laryngoscopy for FBAO removal using forceps, with or without suction
 - Consider surgical airway
 - [→ PR22: Surgical Airways](#)

Evidence Based Practice

[Foreign Body Obstructions](#)

References

1. Kleinman ME, et al. Part 5: Adult basic life support and cardiopulmonary resuscitation quality: 2015 American Heart Association guidelines update for cardiopulmonary resuscitation and emergency cardiovascular care. 2015. [\[Link\]](#)
2. Atkins DL, et al. Part 11: Pediatric basic life support and cardiopulmonary resuscitation quality: 2015 American Heart Association guidelines update for cardiopulmonary resuscitation and emergency cardiovascular care. 2015. [\[Link\]](#)

