Appendix C: Facilitator Cheat Sheet & Debriefing Tips

Key Take Home Points:

1. The ideal intervention:
    a. Direct visualization with a laryngoscope
    b. Removal with Magill forceps
    c. Post-resuscitation care
2. The key to managing pediatric resuscitation is good crisis resource management. Health care providers are heightened by the stakes of the case…nobody wants to see a child have a poor outcome.
    a. Be clear with your tasks – use names, give only 1-2 tasks at a time, ask to be told when task complete
    b. Respect all suggestions – thank suggestions and briefly explain if you choose not to follow a suggestion
    c. Summarize and explain choices so everyone knows your thinking and can make suggestions appropriately
3. BLS management of foreign body removal is all 'indirect', as described in steps above. If this is not possible (friable, liquid), then
    a. Try to get access to the lungs from below the obstruction (cricothyrotomy)
    b. Push the foreign body down one lung with an endotracheal tube, pull the endotracheal tube back a few cm's and ventilate the other lung from above. (Last option and will still require bronchoscopy to ultimately remove the FB)

Epidemiology and Recognition:

- Children <5 years account for >90% deaths from foreign body aspiration; All age children = 65% deaths
- Most common cause of chocking in infants = liquids
- Most common causes of foreign body airway obstruction (FBAO) in children = balloons, small objects, and foods (e.g. hot dogs, round candies, nuts and grapes).
- Signs of FBAO: *sudden* onset of respiratory distress with coughing, gagging, stridor (high-pitched) or wheezing.
- FBAO is distinguishable from other resp causes (eg, croup): A) sudden onset in a proper setting and B) absence of antecedent fever or respiratory symptoms.

Relief of FBAO: FBAO may cause mild or severe airway obstruction.

- Mild – do not interfere. Allow the victim to clear the airway by coughing while you observe for signs of severe FBAO.
- Severe (victim may not be unable to make a sound):
    - Infant: Deliver 5 back blows followed by 5 chest thrusts repeatedly until the object is expelled or the patient becomes unresponsive. *Abdominal thrusts are not recommended because they damage the large and relatively unprotected liver.*
    - Child: perform subdiaphragmatic abdominal thrusts (Heimlich) until the object is expelled or patient unresponsive.
    - Unresponsive: Preform CPR but look into the mouth before giving breaths. If you see a foreign body, remove it. DO NOT perform blind finger sweeps – may push obstructing objects further into the pharynx and may damage the oropharynx.

Prompting questions:

1) Did you feel that your team leader had control over the room? Did he or she ask for input?
2) How do you manage foreign body airway obstruction?
3) What are the advanced techniques available for foreign body removal beyond BLS? What do you do if you can't remove it?

References

1. https://canadiem.org/crackcast-e168-pediatric-respiratory-emergencies-upper-airway-obstruction-and-infections/
2.
3.