Suctioning

Indication: Necessity to clear oropharyngeal or gastric secretions, vomitus, or blood to optimize airway and respiratory conditions.

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GENERAL CONSIDERATIONS:
- **Don proper PPE (gloves, eye protection, and respiratory protection) while suctioning.**
- **Do not suction blindly.** Insert catheter into posterior oropharynx and apply suction while withdrawing.
- **Do not perform oropharyngeal or tracheal suctioning for longer than 10 seconds at a time**, as this can cause hypoxemia. Gastric suctioning may be performed continuously.

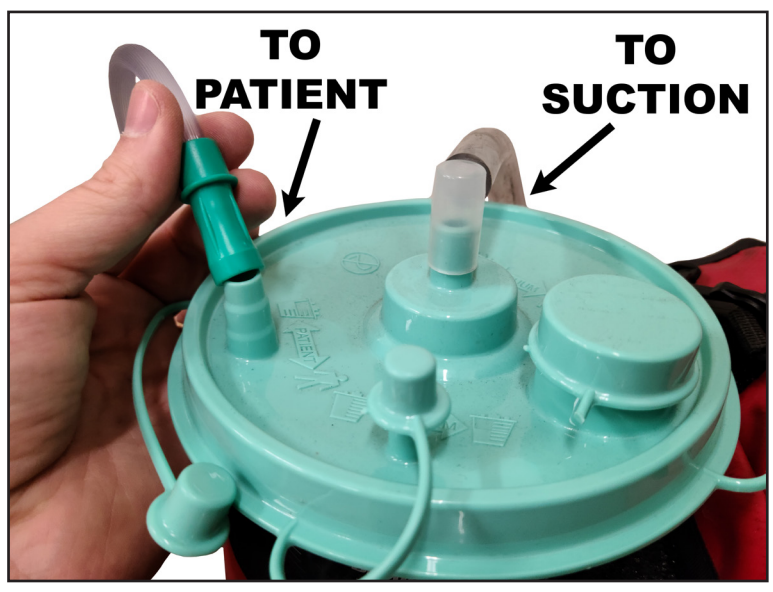
OROPHARYNGEAL:
- Use of a **rigid (Yankauer) suction catheter is preferred**.
- If vomitus is especially thick or has solid contents that block the suction catheter, consider sweeping debris with a finger first. It is also reasonable to suction directly with the suction tubing (no rigid catheter).

TRACHEAL:
- Use a **flexible (French) suction catheter**.
- The bifurcation of the trachea (carina) is located under the Angle of Louis of the sternum.
- If suctioning through an **endotracheal tube, measure from the top of the tube to the carina**.
- If suctioning through a **Tracheostomy Tube, measure from the stoma to the carina**.
- **Do not aggressively suction beyond the carina**, as this may irritate the smaller airways and cause bleeding.

GASTRIC:
- If an **Extraglottic Device (EGD)** is in place, **and the device has an integrated gastric channel** (e.g. AuraGain™, King LTS-D™), gastric suctioning is permitted.
- Gastric suctioning should be considered **if vomitus is impairing ventilation while using the EGD,** and **oropharyngeal suctioning around the device is ineffective.**
- Select a Salem Sump gastric tube and measure **from the tip of the nose, around the ear, and down to the xiphoid process**.
- It is recommended to **use the largest diameter suction catheter that will fit in the channel (see EGD sizing chart)**, as this will help prevent coiling of the tube in the oropharynx and decrease the chance that it becomes clogged.
- **If significant resistance is encountered, STOP your attempt to avoid causing esophageal injury.**
- Gastric suction catheters can remain in place for the duration of the resuscitation and should use **low, intermittent pressure**. Continuous, high pressure can cause the suction catheter to suck onto the wall of the stomach and cause bleeding.
- ***NOTE***: *If a patient received prolonged bag valve mask ventilation prior to EGD placement and gastric distention is appreciated on exam, gastric decompression may improve respiratory conditions.*

OPERATION OF SUCTION DEVICE:
1. Attach suction tubing to the patient port on the cannister.
2. Consider attaching a suction catheter (e.g. Rigid [Yankauer] or flexible [French]) to the suction tubing.
3. Check to ensure that the vacuum line between the suction unit and the cannister is attached at both ends.
4. Turn the suction unit on.
5. Test that the device is providing suction by placing your finger over the end of the suction tubing or catheter.

If the device is on and there is no suction:
- Check the connection of the suction tubing to the patient port on the cannister.
- Check the connection of the vacuum tubing from the suction unit to the cannister.
- Check that the lid of the cannister is tight.



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SUCTION-ASSISTED LARYNGOSCOPY AND AIRWAY DECONTAMINATION (SALAD):
- SALAD is a technique used to optimize intubating conditions in a patient with copious oropharyngeal secretions, blood, or vomitus, particularly when **accumulation occurs so quickly that intermittent suctioning is ineffective to maintain an adequate view of the vocal cords**.
- Correctly performing SALAD technique requires a suction catheter to be left in the oropharynx during the intubation attempt.
- Because the operator will need to remove their hand from the suction to intubate, this technique is **best performed with the suction tubing itself (without a suction catheter)**, since the operator will not be able to actuate the suction of a Yankauer with their thumb.
- After the operator places the suction catheter in the desired location in the oropharynx, an assistant may be used to hold the suction catheter in place during the intubation attempt.

1. **Suction** the oropharynx.
2. **Insert the laryngoscope** into the mouth and advance it to the vallecula (Macintosh blade) or epiglottis (Miller blade), suctioning as necessary.
3. If an adequate view of the vocal cords is obtained, proceed with intubation.
4. If the view of the vocal cords is obscured by recurrent or persistent accumulation of blood, vomitus, or secretions, **insert the suction cathter into the posterior orpharynx / proximal esophagus** as a continuous drain. Consider using an assistant to hold the suction in this position.
   NOTE: *Position the suction catheter to the left side of the patient's mouth so that it does not interfere with intubation. The laryngoscope may need to be repositioned.*
5. Once the oropharynx is decontaminated, attempt to obtain a laryngoscopic view of the vocal cords. If an adequate view of the vocal cords is obtained, proceed with intubation.
   NOTE: *Remove the suction catheter after the endotracheal tube cuff is inflated.*