King Vision Video Laryngoscopy (≥ PL5)

Clinical Indications:

1. Any adult patient who is a candidate for orotracheal intubation with conventional direct laryngoscopy.

Contraindications:

1. The diameter of the oral cavity will not accommodate the blade size:
   a. Channeled blade requires 18mm opening
   b. Non-channeled blade requires a 13 mm opening
2. Anytime a less invasive maneuver would allow oxygenation and ventilation of the patient.

Precautions:

1. During placement of the blade, maintain as anterior of an approach as possible to avoid pooled secretions in the posterior pharynx. Suction should be readily available to manage secretions, blood, and/or vomitus.
2. If suctioning is anticipated, then the provider may elect to utilize the non-channeled blade which can be more easily used in conjunction with suction.
3. Airway axis alignment is generally not necessary but may be employed as provider deems appropriate.
4. Device can be utilized with a c-collar in place.
5. Device should be held below the purple ring during use to avoid inadvertent disconnection, which can occur by lifting on display during use.
6. The following techniques can be utilized to avoid the chest in large body habitus patients:
   a. Insert blade sideways like an OPA and rotate into midline position.
   b. Insert blade without display attached, then attach and turn on while blade is in the mouth.
   c. Ramping may also be effective in these situations.
   d. Blade must be connected before powering device on.
   e. Channeled blade will accommodate 6.0 - 8.0 ET tube

Procedure:

1. Select blade style and attach to display.
2. Lubricate blade and ET tube keeping lubricant away from imaging sensor.
   a. Channeled blade - ET tube should be preloaded into the channel.
   b. Non-channeled blade - A preferred rigid stylet should be placed into the ET tube, or a malleable stylet if a rigid is unavailable as secondary option.
3. Power device on and check for a functional moving image.
   a. If image is static, frozen, or split then power the device off and check connections before turning back on.
4. Place patient's head in a neutral or sniffing position and pre-suction airway.
5. Utilizing a standard scissor technique to open the mouth, place blade in the oropharynx with a mid-line approach, follow the curvature of the tongue looking for the uvula and then epiglottis.
6. Place the blade tip into the vallecula while lifting straight up, displace the mandible anteriorly to expose the glottic aperture (Macintosh approach).
   a. Alternatively, lift the epiglottis directly to expose the glottic aperture (Miller approach).
7. Advance the ET tube through the vocal cords to the proper depth in the trachea.
   a. Channeled blade:
      7.a.1. ET tube can be twisted within channel for lateral adjustment.
      7.a.2. If ET tube impacts right arytenoids retract tube and twist to the left
      7.a.3. Bougie can be utilized for additional anterior deflection
   b. Non-channeled blade:
      7.b.1. Follow blade curve with ET tube tip to avoid losing tip in the oropharynx
      7.b.2. Align ET tube tip with vocal cords
      7.b.3. Retract stylet as ET tube is advanced

8. Stabilize and hold the ET tube laterally while withdrawing blade from the mouth.
9. Disconnect the blade from display. Then dispose of blade, and clean/disinfect display.
10. Cleaning and disinfecting:
    a. Blade is disposable
    b. Display should be cleaned and disinfected with appropriate wipes
    c. Display should not be submersed, and bottom electrical connections should be kept dry at all times.
    d. Stylet cleaning:
        10.d.1. Remove visible contaminants with germicidal wipes
        10.d.2. Allow stylet to air dry
        10.d.3. Rinse stylet with water
        10.d.4. Submerse stylet in Cidex or Sporox bath
        10.d.5. Allow to remain submersed 10-20 minutes
        10.d.6. Remove from bath and allow to air dry
        10.d.7. Rinse with water
        10.d.8. Return to King Vision kit