



Adult King LT-D™/LTS-D™ AIRWAY

INDICATIONS:

A King Airway is for securing an airway during resuscitation of an unconscious patient. A King Airway is an advanced airway technique to assist with oxygenation and ventilation.

A King Airway may be placed by an Orange County Accredited Paramedic in the following situations:

- Primary advanced airway for an unconscious adult/adolescent patient lacking a gag reflex in need of airway protection and ventilation.
- Advanced airway if intubation is anticipated to be difficult and rapid airway control is necessary.
- Advanced airway in adult cardiac arrest when attempts at intubation are likely to interrupt continuous chest compressions.
- Advanced airway when attempted intubation has been unsuccessful.

CONTRAINDICATIONS:

- Intact gag reflex
- Known caustic substance ingestion
- Unresolved upper airway obstruction
- Trismus or limited ability to open the mouth such that the device cannot be inserted
- Oral trauma with bleeding, swelling or unstable jaw fracture
- Distorted anatomy that prohibits proper placement (such as oropharyngeal mass or abscess)
- Patients under 50 kg
- Known esophageal disease
- Laryngectomy patient with stoma (open tracheostomy site or tube)
- Ability to maintain adequate ventilation and oxygenation with less invasive method

PROCEDURE:

1. Assemble equipment:

- Personal protective equipment (gloves need not be sterile)
- Appropriate sized King LT-D™/LTS-D™ *
- Bag-valve-mask
- Stethoscope
- Water-based lubricant
- Means for securing airway device
- Waveform end tidal CO2 capnography
- Pulse oximetry monitoring
- Cardiac monitor
- Optional: 18 French suction catheter if using the King LTS-D™ to decompress stomach.

2. Clear airway with suction and pre-ventilate with BVM plus oxygen and select appropriate size King Airway.*
3. Inflate King Airway cuff to test for leaks. Deflate if cuff intact, discard if leak detected.
4. Lubricate distal tip of King LT-D™/LTS-D™. Avoid placing lubrication in or near ventilation ports.
5. Position the head into the “sniffing position”. Neutral position for suspected cervical spine injury.

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6. Hold mouth open and apply chin-lift maneuver (jaw-thrust for suspected c-spine injury).
7. Introduce the leading SGA soft tip into the mouth in a direction towards the roof of the mouth (hard palate).
8. Using approach to a lateral side of the mouth, introduce the tip into the mouth and advance the tip behind the base of the tongue while rotating the tube to midline so the blue orientation line faces the chin of the patient (this will allow proper placement of the distal tip in the hypopharynx/upper esophagus. Oropharyngeal airways or tongue blades can also be used help facilitate tube placement.
9. Without exerting excessive force, advance tube until base of connector is aligned with teeth or gums.
10. Inflate cuffs with supplied syringe – use minimum inflation necessary to achieve seal for oxygenation/ventilation.
11. Gently ventilate the patient and withdraw the King LT-D™/LTS-D™ until ventilation is easy and without resistance and there are good breath sounds, indicating the device airway openings are well aligned with the laryngeal inlet.
12. Secure airway device using ET tube holder or tape technique.
13. Ventilate with BVM and supplemental oxygen.
14. Monitor capnography, pulse oximetry, and cardiac rhythm until patient care is transferred to receiving center staff (to assure continued proper positioning).
15. If vomiting or forceful gagging occurs, turn patient to side and remove airway device; suction thoroughly and support ventilation further with BVM during transport.

Optional: Insert 18 French catheter through gastric access lumen (King LTS-D™) to decompress stomach.

* Sizing Chart for King Airway

King LT-D™/LTS-D™ size	3 (Optional Equipment)	4	5
Connector Color	Yellow	Red	Purple
Patient Height	4 to 5 feet	5 to 6 feet	Over 6 feet
Cuff Pressure	60 cm H2O	60 cm H2O	60 cm H2O
Cuff Volume LT-D™/LTS-D™	45 – 60 ml/40 – 55 ml	60 – 80 ml/50 – 70 ml	70 – 90/60 – 80 ml

Airway removal

Once a King Airway is placed, it ideally should not be removed. Circumstances that necessitate removal of the device may include inadequate ventilation with the device, return of a gag reflex, or vomiting.

Removal of the device may cause vomiting, use the following steps:

1. Position patient on side, maintain spinal motion restrictions as needed.
2. Have suction immediately available and remove the airway.
3. Reassess airway and breathing to evaluate the need for further assisted ventilation.

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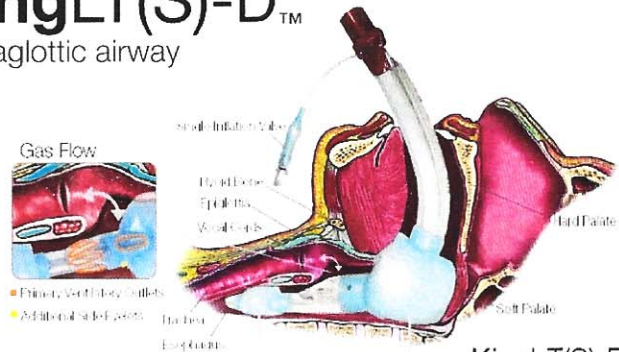
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KingLT(S)-D™
supraglottic airway

Kingsystems



Distal Cuff
Inflates in the esophagus, isolates the laryngopharynx from the esophagus.

Proximal Cuff
Inflates the base of the tongue, isolates the laryngopharynx from the oropharynx and nasopharynx.

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Manufacturer illustration of proper positioned King Airway

PROBLEM SOLVING:

- Air leaking from mouth/nose
 - Confirm good seating of the King LT-D™/LTS-D™.
 - If still leaking add additional 10 mL of air.
 - If still leaking, assume cuff leak and remove tube.
- Unusual circumstances:
 - Patient position; examples: entrapment, arthritis of spine, patient cannot lie flat (supine).
 - Insertion may be attempted as long as ventilation assessment can be completed.
 - Unilateral breath sounds with absent gastric:
 - Pneumothorax.
 - Hemothorax.
 - Pneumonectomy.
 - Facial trauma: If unable to visualize cords for ET insertion or unable to get mask seal with BVM, insert King LT-D™/LTS-D™.
 - Suction prior to insertion.
 - Avoid broken teeth, bone fragments.
 - Maintain spinal motion restriction.

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