Subject: INTUBATION WITH SUCCINYLCHOLINE

A. It is understood that the procedure for endotracheal (ET) intubation is well practiced by the paramedic. This protocol is to provide guidelines for the use of succinylcholine chloride as an adjunct for ET intubation.

Endotracheal intubation should be initiated in a short period of time, so as to prevent delay in the provision of adequate ventilation. Succinylcholine chloride should be used to assist in performing intubation in patients that are difficult, due to the presence of a gag reflex, and where optimal protection of the airway is a potential life-saving maneuver.

B. Have ready, the following equipment and supplies:

1. Bag-valve-mask with functioning O_2 system.
2. Suction unit with rigid pharyngeal tip.
3. Laryngoscope and endotracheal tubes.
4. Lidocaine, Versed, and Atropine (for pre-medication per protocol)
5. Succinylcholine chloride (at least two doses).
6. Versed
7. Vecuronium
8. ***Rocuronium***

C. Ensure that a functioning, secure IV line is in place.

D. Establish cardiac monitor.

E. Assist ventilations with supplemental O_2 as necessary, hyperventilate prior to intubation attempt.

F. Pre-medicate as appropriate.

1. In cases requiring control of intracranial pressure, such as traumatic head injuries, hypertensive crisis, intracranial bleed, or patients at risk for ventricular dysrhythmias, administer **lidocaine**, 1.0 mg/kg, IV bolus.

2. **Versed** is to be used for sedation and amnesia in the conscious patient who requires intubation. Administer **versed** 0.1 mg/kg in patients ≤ 55 and 0.05 mg/kg in patients > 55, to be given IV over 20-30 seconds. To maintain sedation after intubation, give 0.1mg/kg over 2-3 minutes. **Versed** may be given up to a total of 0.5 mg/kg in patients ≤ 55 and up to 0.25 mg/kg in patients

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> 55. Monitor blood pressure after each administration of **versed**. Titra the dosage to maintain desired level of sedation without causing systolic BP to drop below 110.

If amnesia via sedation is desirable and IV access is unobtainable, may give a single buccal dose of 10 mg.

G. In cases of unconscious head-injured, multi-trauma, or CVA patients, to help prevent intrcranial pressure administer 1/10 dose of **Vecuronium** IV. Wait 30-60 seconds and then administer **succinylcholine**, 1.5 mg/kg, IV slow push ***(preferred), or Rocuronium, 1.0 mg/kg, IV***. You will not see fasciculation from the administration of **succinylcholine. Succinylcholine** may be administered IM if after multiple attempts at an IV, no IV access obtainable.

H. Perform direct laryngoscopy and place ET tube per protocol. Occlude the espohagus by applying cricoid pressure (Sellick Manuever) until the intubation is successfully completed. The Sellick Manuever should be used in all patients requiring intubation.

1. If first attempt is unsuccessful, ventilate with BVM for 30-60 seconds.

2. If relaxation is inadequate, administer a second dose of **succinylcholine**, 1.0 mg/kg, IV slow push.

I. If repeated intubation attempts fail, ventilate with BVM until spontaneous respirations return. If further intubation attempts fail, and patient cannot be ventilated per BVM, consider other airway adjuncts and/or perform cricothyroidotomy per protocol.

J. In the event that bradycardia occurs during the intubation attempt, cease intubation attempts and ventilate per BVM with supplemental O_2.

K. After successful intubation, consider 2 mg of **morphine** IV if BP is >100 systolic. Check BP after 5 minutes. If BP is >100 systolic repeat 2 mg IV **morphine** dose. The 2 mg dose IV may be repeated q 5 minutes up to 0.1mg/kg checking BP before each administration.

L. **Succinylcholine** is contraindicated in burn victims if burn is post 6 hours.

M. Consider administration of **vecuronium** to combative patients after successful endotracheal intubation. In a dose of 0.1 mg/kg of **vecuronium** IV.

1. Administer 0.1 mg/kg IV bolus. The expected duration of action is 25-30 minutes.

2. If patient is hypotensive, do not administer **morphine**.

3. Continued end tidal CO2 monitoring is necessary.

4. Continued SaO_2 monitoring is necessary.