CODE READY

Acute Airway Obstruction

Stepwise clearing and securing of the obstructed airway using basic manoeuvres and adjuncts available at upazila level. Noisy breathing is obstructed breathing; silence in a struggling patient is worse.

1. RECOGNISE

- [ ] **Snoring, gurgling or stridor = partial obstruction**
- [ ] **Silent chest with respiratory effort, see-saw breathing = complete obstruction**
- [ ] **Cyanosis and falling conscious level are late signs**
- [ ] **Identify the cause: tongue (unconscious), fluid, foreign body, swelling (burns, anaphylaxis, infection)**

2. OPEN AND CLEAR

- [ ] **Head tilt-chin lift (jaw thrust only if trauma suspected)**
- [ ] **Suction visible blood or vomit under direct vision — never blindly deep**
- [ ] **Choking conscious adult: 5 back blows then 5 abdominal thrusts, repeat**
  Infants: 5 back blows then 5 chest thrusts; no abdominal thrusts
- [ ] **Remove a visible foreign body with Magill forceps; finger sweep only if clearly seen**

3. MAINTAIN

- [ ] **Oropharyngeal airway if unconscious with no gag reflex**
  Size from incisors to angle of jaw
- [ ] **Nasopharyngeal airway if gag reflex present**
  Avoid in suspected base-of-skull fracture
- [ ] **Recovery position if breathing and no spinal concern**
- [ ] **High-flow oxygen 10-15 L/min for all**

4. ESCALATE

- [ ] **Assist ventilation with bag-valve-mask if breathing is inadequate**
  Two-person technique: one seals the mask, one squeezes the bag
- [ ] **Anaphylaxis with airway swelling: adrenaline 0.5 mg IM immediately**
- [ ] **Call the most airway-skilled person available; arrange urgent referral for a definitive airway**
- [ ] **Keep suspected epiglottitis or burn-swelling patients sitting up; never force them flat**