

The i-gel is the name for a particular manufacture model of a second generation supraglottic airway (SGA) device. The i-gel replaces the King LT Airway.

Criteria:

- Unconscious patient without a gag reflex requiring airway management

Contraindications:

- Intact gag reflex.
- Caustic ingestion
- Trismus (reduced opening of the jaws from spasm or other cause), limited mouth opening, or inability to pass the i-gel device without excessive force.

Procedure:

1. Estimate body weight and choose size based on weight and i-gel size availability:

i-gel Size	Broselow	Patient size	Patient weight (kg)/(lb)
1		Neonate	2-5 kg / (approx. 4-11 lbs)
1.5		Infant	5-12 kg / (approx. 11-26 lbs)
2		Small Pediatric	10-25 kg / (approx. 22-55 lbs)
2.5		Large Pediatric	25-35 kg / (approx. 55-77 lbs)
3		Small Adult	30-60 kg / (approx. 66-132 lbs)
4		Medium Adult	50-90 kg / (approx. 110-200 lbs)
5		Large Adult +	90+ kg / (approx. 200+ lbs)

2. Prepare i-gel per manufacturer’s guidelines.
3. Open the lubricant and place a small bolus on the inner side of the i-gel cradle (see video).
4. Lubricate the back, sides, and front of the i-gel with a thin layer of lubricant
5. Grasping the i-gel firmly along the bite block, open the airway.
6. Position the device so the i-gel O2 cuff outlet is facing the patient. Introduce the leading soft tip into the mouth of the patient in the direction of the hard palate.
7. Glide the device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt.
8. The tip of the airway should be located into the upper esophageal opening with the cuff located against the laryngeal framework. The incisors should be resting on the bite block.
9. For sizes 3-5, secure the device by sliding the strap underneath the patient’s neck and attaching to the hook ring. Take care to ensure the strap is not secured too tightly around or too low on the neck. For sizes 1-2.5, the device can be secured by taping maxilla to maxilla.

10. Commence with positive pressure ventilation per appropriate protocols. (When ALS become available, end-tidal CO₂ monitoring should be initiated)
11. Assess quality of ventilation (listen to lung sounds, observe chest rise, and monitor pulse oximetry)
12. Reassess tube placement frequently, especially after movement of the patient.
13. Document the time, provider, provider level and success for the procedure.
14. Complete all applicable airway confirmation fields including chest rise, bilateral, equal breath sounds, absence of epigastric sounds and (for ALS) end-tidal CO₂ readings.

i-gel PEARLS:

- Insertion can generally be achieved in less than 5 seconds.
- Sometimes a feel of “give-way” is felt before the end point resistance is met. This is due to the passage of the bowl of the i-gel through the faucial pillars. It is important to continue to insert the device until a definitive resistances is felt.
- Once correct insertion is achieved and the teeth are located on the integral bite block, do not repeatedly push down or apply excessive force during insertion.
- If there is resistance, remove and re-lubricate and reposition the airway before repeat insertion. However, no more than (3) attempts on one patients should occur.
- It is not necessary to insert fingers or thumbs into the patient's mouth during insertion.
- If required and equipment available, ALS may pass an appropriate size nasogastric tube down the gastric channel.

A note regarding dentures:

- Dentures may be left in place during initial bag valve mask ventilation to improve quality of mask seal. However, prior to i-gel insertion dentures should be gently removed to prevent them from becoming a loose foreign body in the airway. Simply gently pull out the dentures and proceed. If dentures are tightly adhered or are not easily removable, leave them in place and notify ALS and/or ED staff upon transfer of care.

Training video supplement:

A training video on the iGel is available at <https://www.youtube.com/watch?v=Z0962B8axAY&feature=youtu.be> and is also posted in Target Solutions.



Matthew F. Russell, M.D.
Skagit EMS Medical Program Director