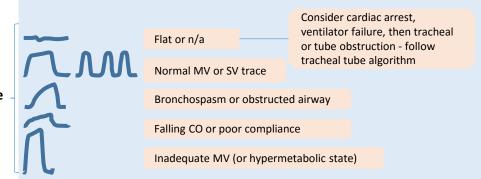
Sudden hypoxia on the ICU – cause not clear

- 1. Call for help
- 2. 100 % inspired oxygen
- 3. Check end tidal CO2 trace



- 4. Tracheal suction (in-line if present, or use suction catheters)
- 5. Assess chest movement and listen to chest

Findings	Diagnoses to consider	Management
Obstructed appearance (see-sawing), bilaterally quiet, ↓Expansion & compliance	Consider tracheal or tube obstruction	Follow tracheal tube algorithm. Then consider these:
Quiet & reduced expansion on one side , + reduced compliance	Endobronchial intubation Has ETT moved in further (usually not more than 24cm at teeth)?	Consider withdrawing 1-2 cmCXR +/- bronchoscopy
	Pneumothorax or haemothorax Trauma, new line or drain, high ventilation pressure, in-situ chest drain fault.	 Needle decompression or drain (or resolve drain issue). CXR/CT if stabilises
	Pulmonary haemorrhage Bronchiectasis, abscess, TB, or tumour?	Airway specialist and thoracic surgeon involvement.CXR/CT
	Collapse/atelectasis due to sputum, or aspiration	 Suction (+/- saline) Recruitment breaths with ventilator or bag Consider bronchoscopy
New widespread wheeze +/- reduced compliance	Bronchospasm	 Suction ECG/CXR +/- Echo/troponin Consider Bronchodilators/steroid Furosemide/nitrate Stop feeding, empty stomach Bronchoscopy
New widespread crackles +/- reduced compliance	Pulmonary oedema New ischaemia Recent fluid bolus Aspiration Feeding tube malposition Vomiting	 Suction ECG/CXR +/- Echo/troponin Consider Furosemide/nitrate Stop feeding, empty stomach Bronchoscopy
Normal breath sounds and compliance	Low cardiac output state MI PE Haemorrhage Tamponade	 ECG/Echo Assess volume status (?CO monitoring, PPV) FAST/CT