Clinical Indications:

1. Patient meets clinical indications for oral intubation
2. Initial intubation attempt (s) unsuccessful
3. Predicted difficult intubation
4. To facilitate intubation without interruption of CPR

Contraindications:

1. Do not use with endotracheal tubes less than 6.0 mm

Technique:

1. Introducer may be lubricated with sterile lubricant such as surgilube.
2. Perform an optimal direct laryngoscopy. Visualization of vocal cords may be enhanced by an assistant using tracheal manipulation such as the BURP maneuver.
3. Introduce the bougie with the Coude Tip anteriorly positioned and visualize the tip passing through the vocal cords. An alternative technique if the cords cannot be visualized is to use the epiglottis as a landmark and pass the tip of the bougie directly below the epiglottis.
4. Tactile confirmation of tracheal clicking will be felt as the distal tip of the bougie bumps against the tracheal rings. This "clicking" will also be felt by the assistant performing tracheal manipulation such as the burp maneuver. If tracheal clicking cannot be felt, continue to advance the introducer until "hold- up" is felt. Tracheal clicking or "hold-up" are positive signs that the bougie has entered the trachea. No clicking or "hold-up" is indicative of esophageal placement. The distal tip of the bougie should lie at least 2-3 cm beyond the glottic opening.
5. While holding the introducer and holding the laryngoscope in place, have an assistant advance the endotracheal tube over the proximal end of the bougie (the bougie may be "pre-loaded" with the endotracheal tube prior to insertion). Once the endotracheal tube passes the teeth, rotate the endotracheal tube 90 degrees counterclockwise (1/4 turn to the left) so that the endotracheal tube does not get catch on the arytenoid cartilage.
6. Continue advancing the endotracheal tube to the proper depth.
7. Holding the endotracheal tube securely, remove the bougie.
8. Confirm endotracheal intubation (Procedure 3).
9. The bougie is not reusable.