

**Rescue/Extrication:**

**Always contact Fire/Rescue if any question of provider safety.**

Consider  
Trauma

Spinal Immobilization

1-06

**Aggressive Airway Management & Ventilatory Support:**

- Consider starting ventilations prior to removal from the water.
- **100% Oxygen by Non-Rebreather**, as per Airway/O<sub>2</sub> Maintenance [A-01]
- **Early & aggressive Positive-Pressure Ventilation (PPV)**
  - If normal mentation → CPAP/BiPAP [A-P4]
  - If decreased LOC → Intubation/RSI [A-04]
- Consider **bronchodilators** for wheezing/bronchospasm, as per Asthma/COPD [A-06]
- Consider gastric decompression if OG Tubes are available (and the paramedic has completed in-service training),.

Provide Basic Hemodynamic Support:

- **IV/IO Access**, per IV Protocol [1-03]
- **Fluid Resuscitation and Vasopressors**, per Medical Shock [M-06]
- Treatment of Dysrhythmias as per Guidelines [C-TOC]

Consider

Hypothermia Guideline

E-06

**All Near-Drowning Patients Should be Transported to the Emergency Department for Observation**

E-03 NEAR DROWNING		
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### KEY POINTS:

- Near-Drowning = Immersion injury of sufficient severity to warrant medical attention, and that may lead to morbidity and death. Drowning = immersion injury with resultant death.
- “Dry drowning” = laryngospasm persists until cardiac arrest (10-20%), otherwise is “wet drowning” (fluid enters lungs).
- Pathophysiology:
  - Hypoxemia leading to acidosis and ultimately CNS damage and cardiac arrest.
  - Even after survival of the initial immersion, fluid aspiration can cause pulmonary surfactant washout leading to atelectasis and ventilation-perfusion (VQ) mismatch. This leads to hypoxia from the perfusion of the non-oxygenated (non-ventilated) lung. Ultimately this can cause “*secondary drowning*” = death due to development of ARDS/hypoxia.
- Concurrent trauma should be considered on all patients, especially head and neck/spinal injuries.

### QI Review Parameters:

1. Pending