Prolonged tracheal intubation: the problem of changing the tube: an easy solution

Sir.—Prolonged tracheal intubation is commonly used, as an alternative to tracheostomy, in a variety of conditions—coma, respiratory distress—and has gained the favour of many anaesthetists, since it is easily performed, and avoids some of the well-known complications of tracheostomy.

Intubation may be achieved through the oral or the nasal routes, the nasal being favoured by most, since it is more acceptable to a conscious patient, and less likely to lead to complications such as biting on the tube or displacement.

However, whether the tube is introduced through the nose, the mouth or a tracheostomy, it is likely to become obstructed by plugs of mucus, blood or secretions, and therefore has to be removed and replaced by a new one.

The replacement is not always easy, since the patient may be unco-operative or in severe respiratory distress, and the procedure has to be carried out as an emerg-ency. Blind nasal intubation is not always successful at the first attempt; laryngoscopy may prove difficult, if not impossible, and may induce trauma. Even in the case of tracheostomy, on a fat, short-necked patient, unless the tube has been in site for some time and the route well established, changing a cannula is likely to be a problem.

We have tried successfully a simple technique, which makes the exchange quick and simple. A lubricated stiff ureteral catheter is first inserted within the tracheal tube, whether nasal, oral or tracheostomy; this serves as a guide along which the tube is removed and the new one re-inserted. The whole procedure lasts only a few seconds; it saves time and avoids manoeuvres.

We suggest, without having any experience on the subject, that, if secretions are suspected, a Fogarty catheter might be used, the balloon inflated, and the trachea swept, in one stroke, such as is done in case of arterial embolism.

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