DOUBLE RETRO-MOLAR INTUBATION (DRI)

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Introduction

Retro-molar intubation remains a form of orotracheal intubation. The difference is that the anæsthetist or surgeon leaves the endotracheal ventilation device displaced retromolarly or retrotuberously; the patient is usually able to close the mouth without disturbing the occlusal inter-relationship. Sometimes, that space may have to be widened surgically.

Material and Method

When that cannot be done due to interference from the endotracheal tube, the surgeon widens the space in that area, usually by extracting one of the wisdom teeth, by abrading the distal alveolar ridge, or by sacrificing one of the more distal teeth; that is usually the lower molar on the side where the endotracheal tube will finally be positioned to carry out surgery or proposed ventilation, etc.

To perform the procedure, we use a ringed endotracheal tube specially designed for similar effects, based on established designs (e.g. layout, shape, etc.). It is bifurcated and of smaller calibre, but it goes distally beyond the oropharynx and the supraglottic space. With no break, it progresses intra-orally to become peribuccally externalisable, for ventilation and surgery.

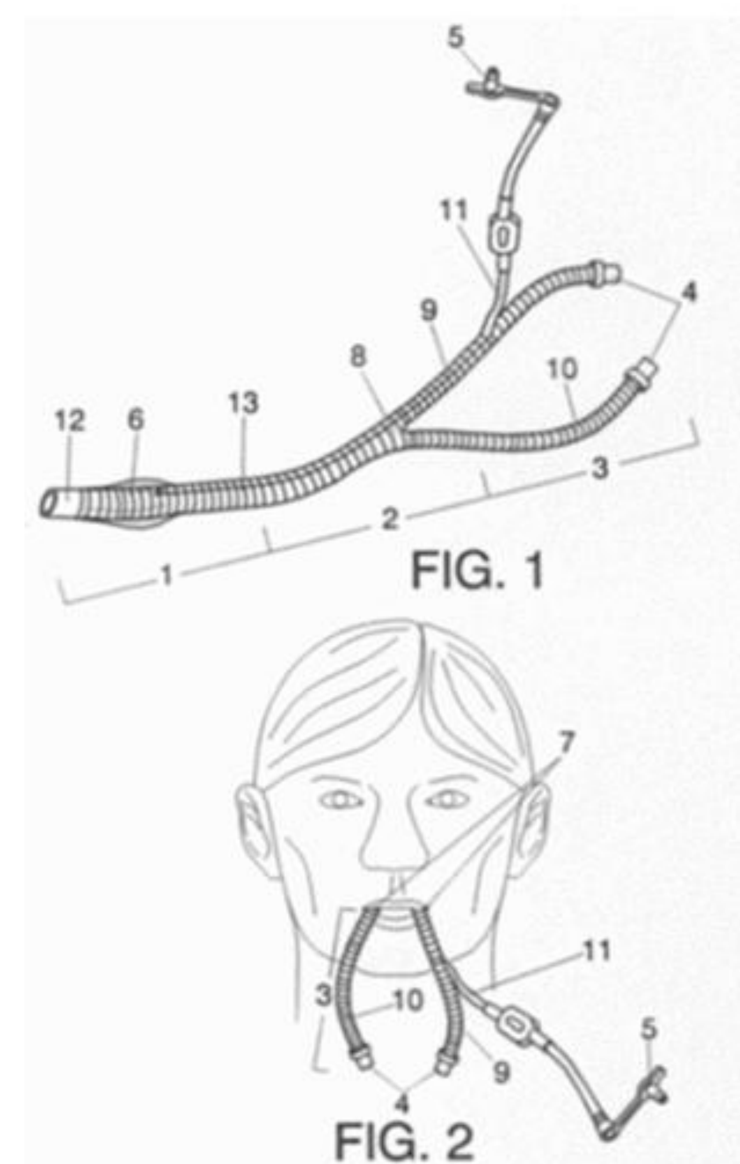

FIG. 1

FIG. 2

Conclusions

DRI is based on experience in applying traditional submental intubation. It may be indicated in specific cases involving multidisciplinary pathology in the oral and cranio-maxillofacial fields, when the reason is a desire to avoid the external scar caused by ordinary submental intubation.

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