

# A MODIFICATION IN OROTRACHEAL INTUBATION USING AN EXTRA-SHORT, RINGED TUBE: A NEW TECHNIQUE

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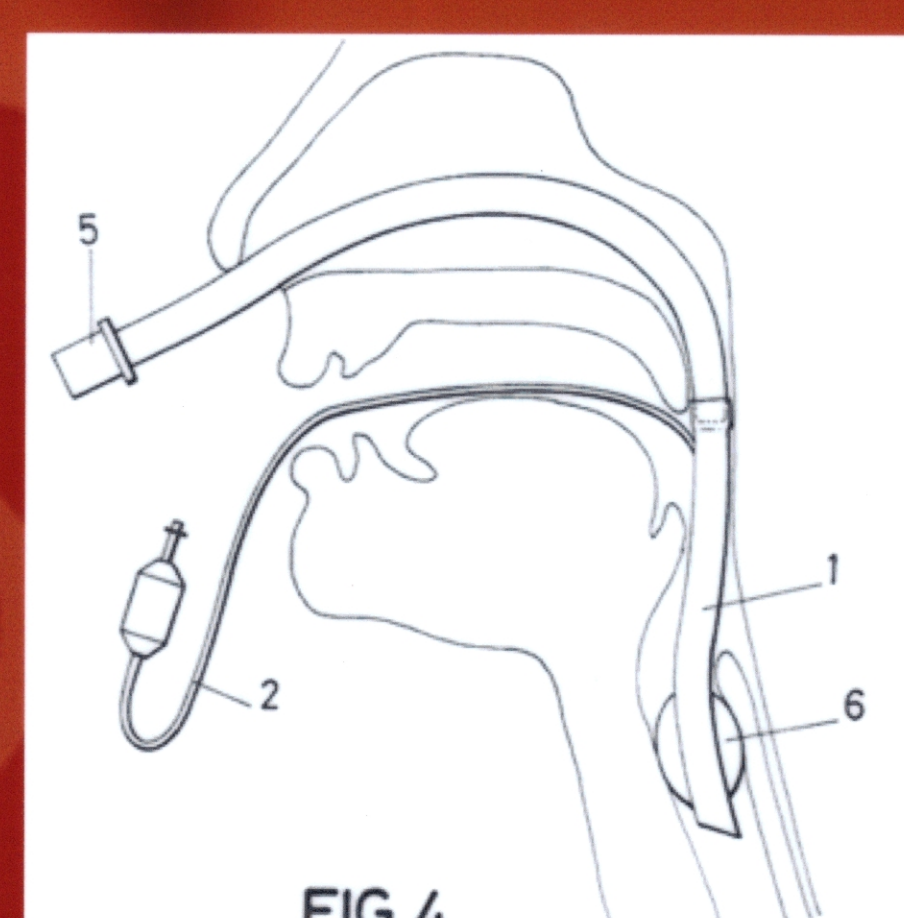
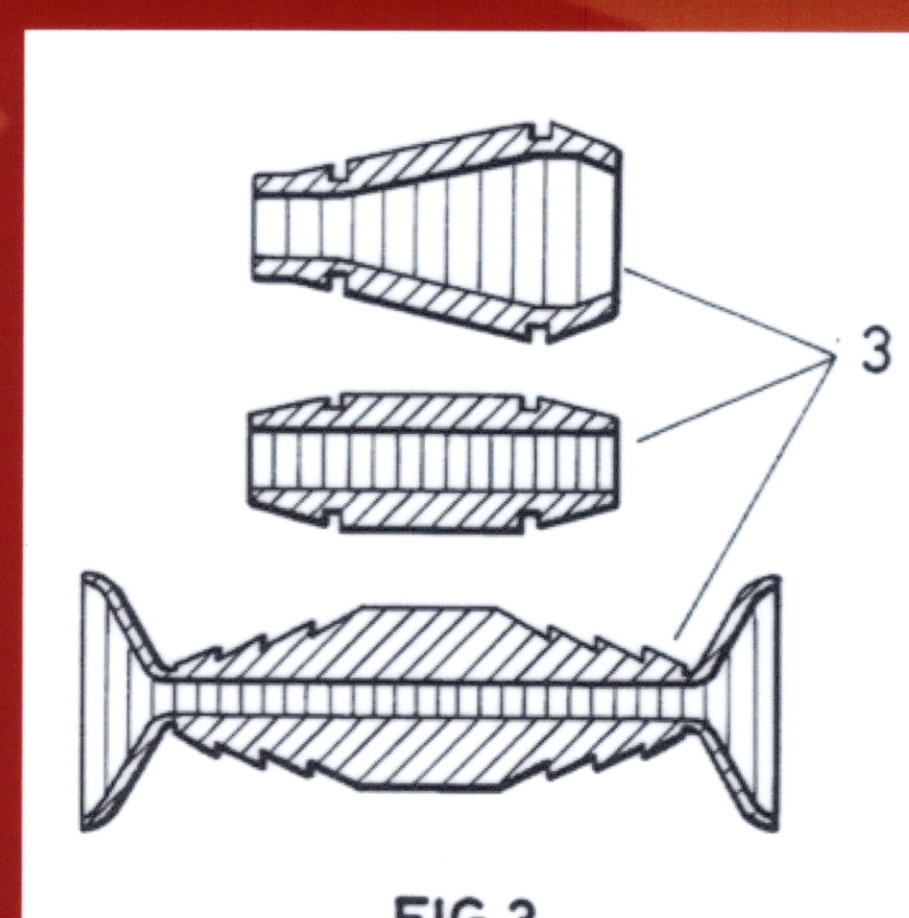
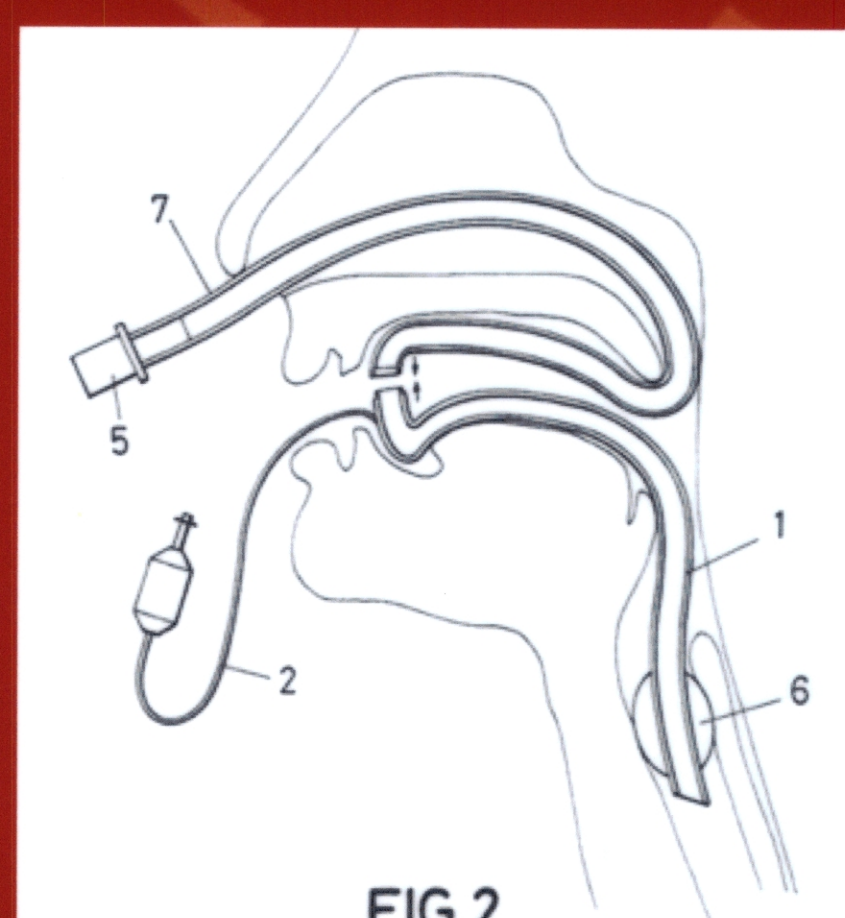
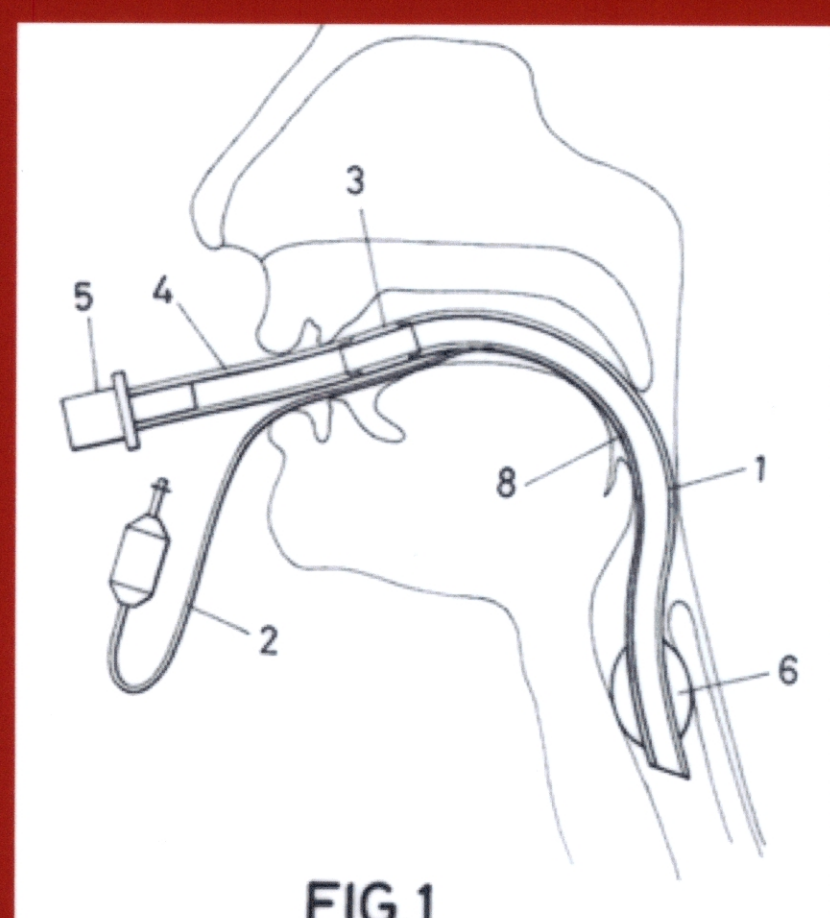
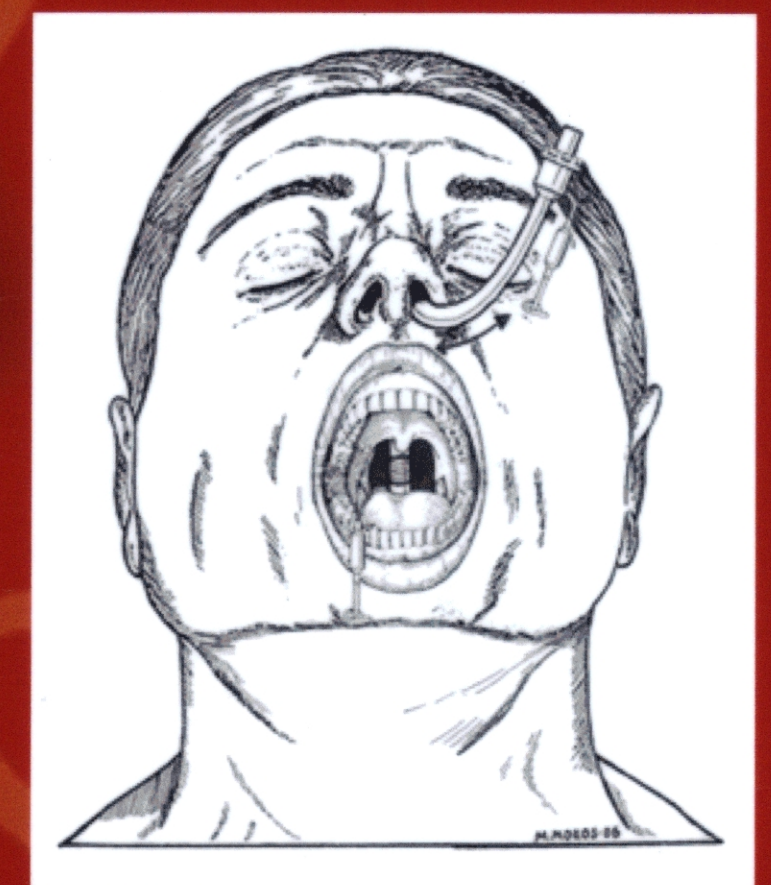
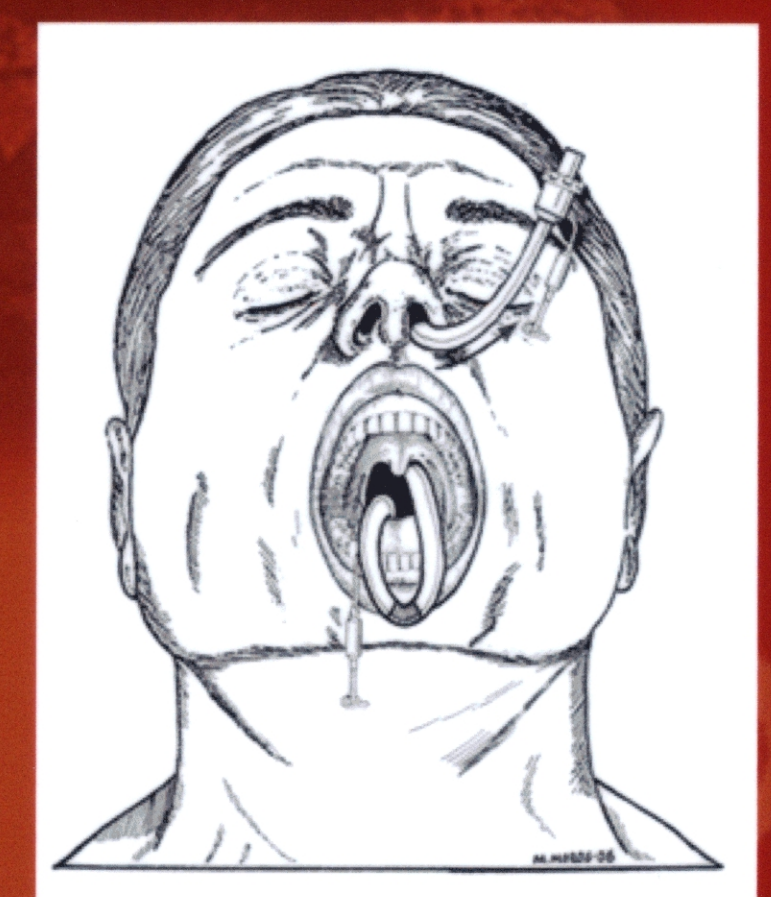


## INTRODUCTION:

It is clear that in our field, where nasotracheal intubation, so apt for the great majority of the most common surgical procedure in oral and maxillofacial surgery and related specialities, continues to be an extraordinary type of intubation for anesthesiologists. The endotracheal tube and the tubes from the ventilation system are a great technical inconvenience, sometimes making certain surgical actions impossible if they are located in the oral region, a fact apparently not always understood by the anesthesiologist. To overcome these difficulties, we have developed a new way of providing all the advantages of orotracheal intubation, with mechanical ventilation support, provided through the nasal route.

## MATERIAL AND METHOD:

The anesthesiologist proceeds with the orotracheal intubation using the prepared endotracheal tube (This modification involves reducing the tube's total length in the following way: the connector is removed from the proximal portion of the tube and the smallest possible double connector is coupled to it). The anesthesiologist inserts the wedge between the arches, and the oropharyngeal tamponage. This done, the anesthesiologist, will introduce the chosen ringed nasal tube into the most suitable nasal fossa. It is installed as far as the oropharyngeal space, above the tamponage, from where the anesthesiologist will take hold of it and bring it out of the oral cavity, and immediately connect it to the orotracheal tube's connector, the ventilation tubes being removed before hand, that will be connected immediately to the proximal connection of the nasal tube, in order to maintain patient ventilation. Next the anesthesiologist will pull on the nasal tube, that has been previously been connected firmly to the orotracheal tube, in such a way that, accompanied by the anesthesiologist's hand, it is brought to the pre-uvular or slightly retro-uvular space. Once the surgical procedure activity is completed, the orotracheal intubation will be removed, following the intubation path in reverse, sending the opening of the endotracheal tube back to its position outside of the mouth. Next, disconnecting the nasal tube from the orotracheal tube connection, and proceed with the usual intubation removal procedure.



## CONSIDERATIONS:

There is no doubt that whenever there are no overriding reasons that contraindicate a nasotracheal intubation, always precise and requiring experience, our alternative, we believe, can be considered, given that it does not break, to all intents and purposes, with the non-specialised anaesthesiologist's routines in the practice of the often complex surgery in the oral and maxillofacial field.



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