

# SUBMENTAL INTUBATION UNDER FIBROSCOPE: A NEW TECHNIQUE

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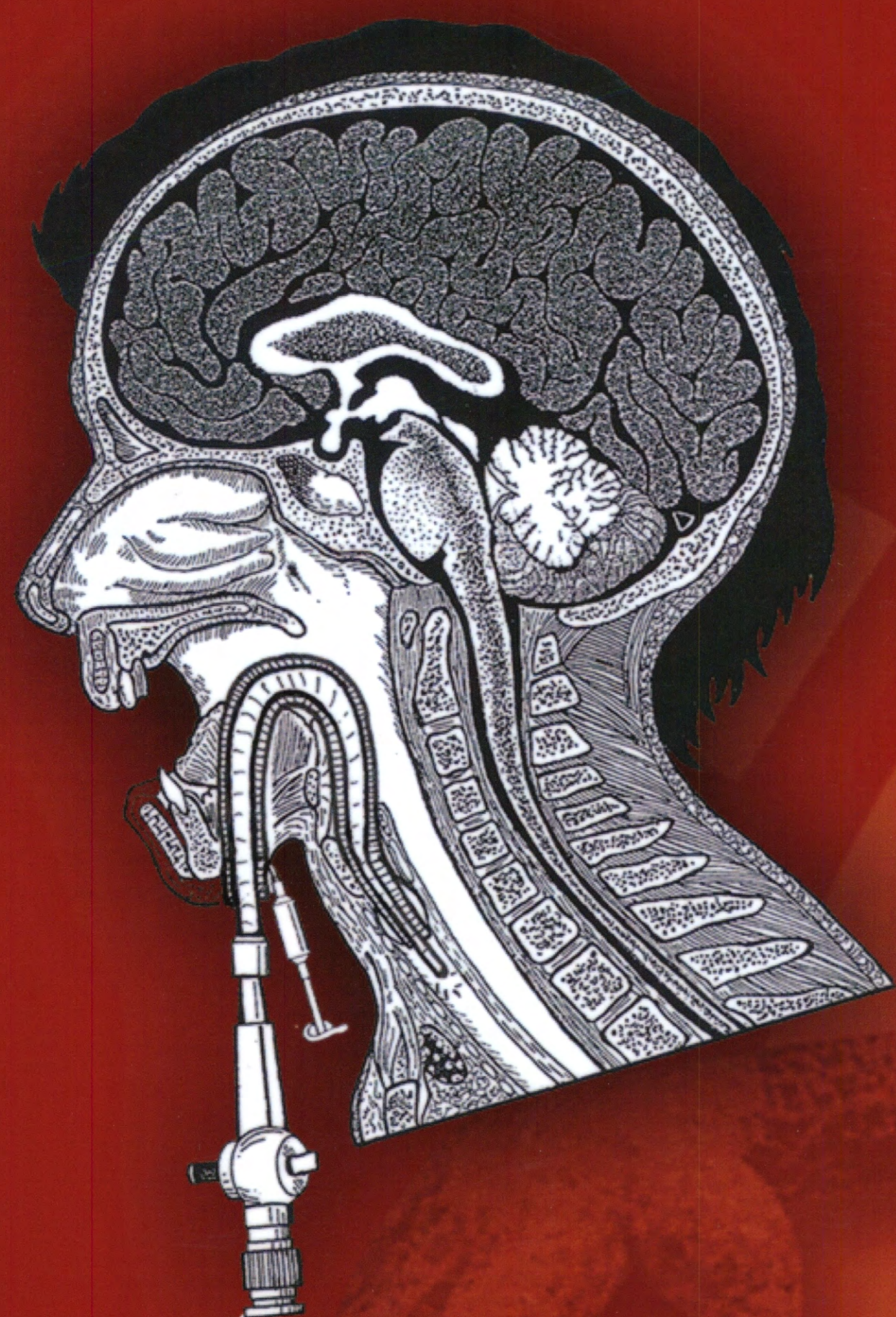
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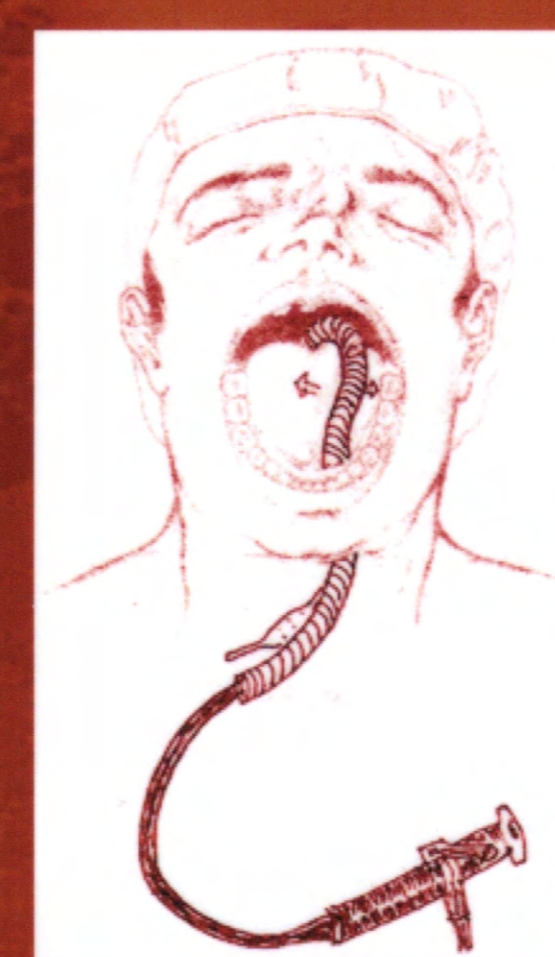


## INTRODUCTION:

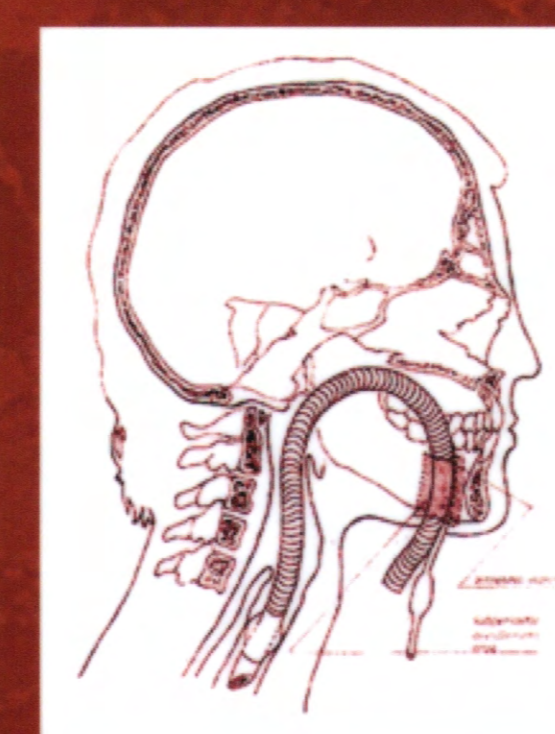
Submental route for endotracheal intubation already is a relatively frequent procedure in Oral and Maxillofacial Surgery and close specialities, as is found in the numerous international references. We report now one modification of conventional submental intubation, using fibroscope through the submental route associated or not to nasotracheal intubation through fibroscope.

## MATERIAL AND METHOD:

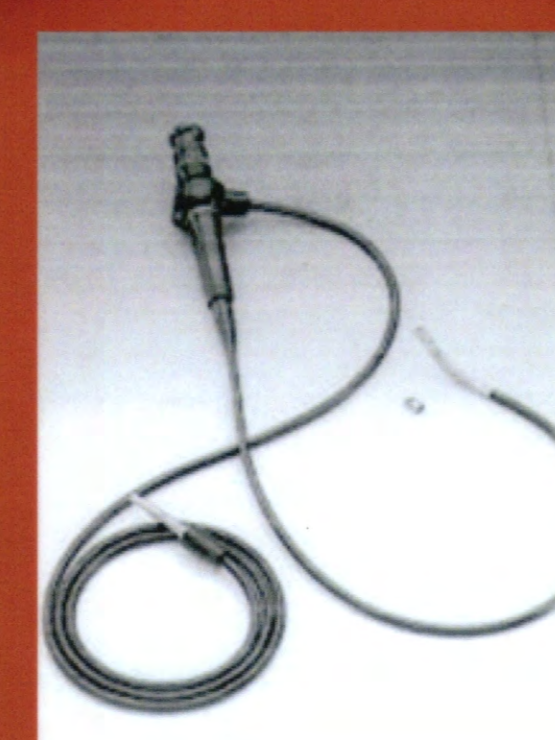
We use the conventional bronchoscopy fibrosopes and ringed tubes (Rüschelit® Tracheal Tube), what represents they are bigger than those used in nasotracheal intubation under fibroscope, with the resulting advantage, mainly for postoperative period and the units of reanimation and intensive care. The anaesthetic procedure of submental intubation under fibroscope, is not different that the one used for nasotracheal intubation under fibroscope. First the local anaesthesia of the area and the skin incision followed by the design of the subperiostic tunnel are done. Then with the help of a rhinoscope to support the tunnel the ringed tracheal tube inserted in the fibroscope, pass together through it, from the skin to the floor of the mouth, and reach, first with the fibroscope, the supraglottic space, introducing it in the laryngotracheal space, until glancing the carine, to slip the ringed tracheal tube to its laryngotracheal location, in the same way as in the submental intubation technique.



The fibroscope and ring tracheal tube are both located at the laryngotracheal location at the same time.



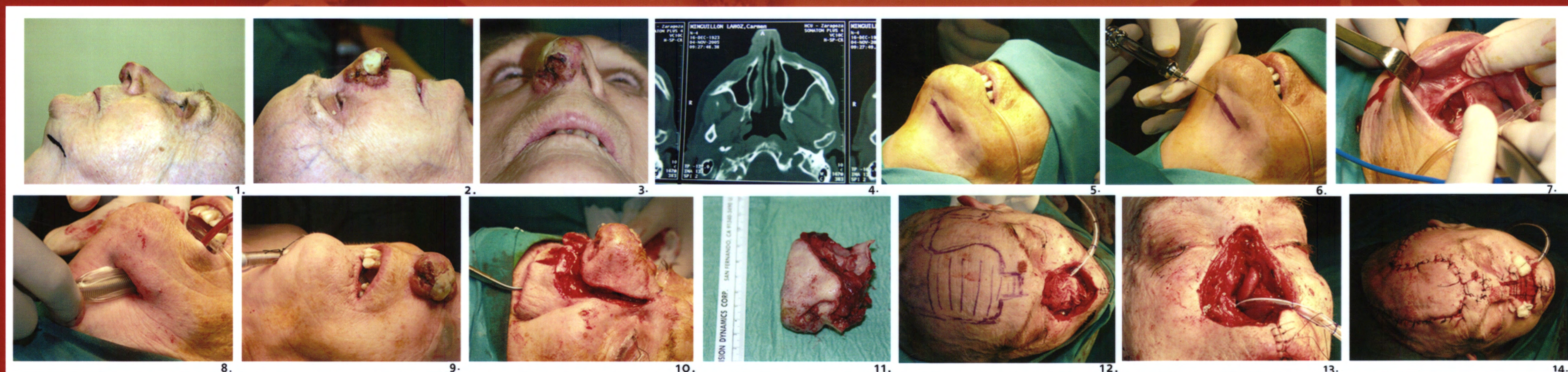
The submental intubation finished.



The fibroscope support the ring tracheal tube and reach under submental intubation the laryngotracheal space.

## DISCUSSION:

The procedure is indicated for selected cases, mainly in patients that have a severe limitation to mouth or maxillo-mandibular opening, or in those ones in which nasotracheal intubation through fibroscope is not possible. With this procedure we avoid the transposition of the orotracheal tube to the submental space, this is, from a septic cavity to a sterile surface, besides the advantage of not having to release the endotracheal tube connection. It is not either necessary as big incisions as those of the conventional technique.



XVIII Congress of the European Association for  
Cranio-Maxillofacial Surgery

Barcelona • September 12th to 16th 2006