Determination of tracheal tube insertion depth for dental procedure and oral and maxillofacial surgery

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Introduction

Incorrect endotracheal placement of the tracheal tube can lead to serious complications, such as laryngeal nerve paralysis and accidental extubation [1]. In oral and maxillofacial surgery and dental procedure, the head of the patient was covered in drape, and an anesthesiologist cannot often see tracheal tube. In addition, surgeon (or dentist) may move the head of the patient. Flexion of the neck results in increase in the insertion depth of tracheal tube [2,3]. Conversely, extension of the neck results in decrease in the insertion depth of tracheal tube [3]. Position of the neck results in the insertion depth of tracheal tube is presented in Figure 1.

Thus, it is necessary to decide exactly a tube position in the oral and maxillofacial surgery and dental procedure. On some tracheal tube, a marker is included on tracheal tubes in the process of manufacture, as an index that the cuff has passed the glottis. The position of the carina is not taken into consideration when the marker is used as an index to determine accurate tube placement. On other hand, on some tracheal tube, there is not a marker. Traditionally, to assess the accuracy of tube placement, equality of breath sounds on bilateral chest auscultation has been used for verifying the position of the tube after tracheal intubation in the operating room. The equality of breath sounds on bilateral chest auscultation is a poor diagnostic modality for assessment of endobronchial intubation [4]. And, the distance between the carina and the tube tip cannot be measured. Thus, I recommend continuous breath sound method, this method determine it as reference as the point of changes in breath sounds by continuous chest auscultation.

Figure 1. Change of head position and displacement of position of the tracheal tube.

Determination of tracheal tube insertion depth with continuous breath sound method

Anesthesia was induced with sedative anesthetic, analgesic and muscle relaxant. Tracheal Tube was inserted through oral or nasal after lubrication with jelly. Under laryngoscopy, when it was confirmed that the cuff of the tube had passed through the glottis, measurement was made on the tube (Figure 2 (Left)). The measurement of tracheal tube length must assess on the uniformity position, e.g. such as nose or front

Figure 2. Process for determination of tracheal tube insertion depth with continuous breath sound method.

*Under laryngoscopy, it was confirmed that the cuff of the tube had passed through the glottis (left). Breath sounds from the left side of the chest changed in quality (becoming rough, bubbling, wheezing or bronchial) (right).

*Extension and rotation of the neck results in decrease of 2.5 cm in the insertion depth of tracheal tube.

*Flexion of the neck results in increase of 2 cm in the insertion depth of tracheal tube. Conversely, extension of the neck results in decrease of 2 cm in the insertion depth of tracheal tube.

Key words: maxillofacial surgery, dental procedure, tracheal tube

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Table 1. Tracheal length (cm) on continuous breath sound method, and on chest radiograph with calculation.

<table>
<thead>
<tr>
<th>ID</th>
<th>On continuous breath sound method</th>
<th>On radiograph</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13.5</td>
<td>13.6</td>
<td>-0.1</td>
</tr>
<tr>
<td>2</td>
<td>13.5</td>
<td>12.7</td>
<td>0.8</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>13.7</td>
<td>0.3</td>
</tr>
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<td>2</td>
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<tr>
<td>5</td>
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<td>11.7</td>
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<td>6</td>
<td>14.5</td>
<td>12.1</td>
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<tr>
<td>7</td>
<td>13.5</td>
<td>12.7</td>
<td>0.8</td>
</tr>
<tr>
<td>8</td>
<td>13.5</td>
<td>12.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>13.6 ± 0.6</td>
<td>12.6 ± 0.7</td>
<td>1.0 ± 0.8</td>
</tr>
</tbody>
</table>

Accuracy for continuous breath sound method

The continuous breath sound method has been used for determining proper tube position after tracheal intubation in the operating room [5-8]. The continuous breath sound method is applicable to all patients such as adult and pediatric. In particular, it is useful for pediatric patients, because appropriate tube length is different. In the continuous breath sound method, breath sounds changed in the left bronchus as the tube was inserted beyond the carina and entered the right bronchus, interrupting gas flow to the opposite bronchus [7]. In the continuous breath sound method, when breath sounds disappeared, the tube was withdrawn to its previous position, to the point of change in breath sounds. Therefore, breath sounds changed was indicated the distance to the carina. To indicate position of the carina, it is important that an anesthesiologist to examine by a stethoscope does not miss the chest changed in quality (becoming rough, bubbling, wheezing or bronchial) but not the chest disappeared. Normal breath sounds could be heard from the left side of the chest until the tracheal tube tip was advanced beyond the carina, and inserted into the right bronchus more deeply in the tracheal tube with murphy eye than in the tracheal tube without murphy eye [8]. Tracheal tube with murphy eye may reduce the reliability of breath sound in detecting. Thus, in the continuous breath sound method, it is necessary to note that, murphy eye produces an error, and not miss the chest changed in quality.

In study of determination of tracheal tube insertion depth with continuous breath sound method, in case of short of the distance from the tube tip to the carina (less than or equal to 2 cm), tracheal length was evaluated using a preoperative chest radiograph. The case of short of the distance from the tube tip to the carina was 8 cases, in total 78 cases. Tracheal length on preoperative chest radiographs was calculated using the distance from C6 to the carina and the distance from the glottis to the cricoid cartilage, which is located at C6 [9,10]. The mean tracheal length on continuous breath sound method was 13.6 ± 0.6 cm, the mean tracheal length on chest radiographs with calculation was 12.6 ± 0.7 cm. Difference between tracheal lengths by two methods was 1.0 ± 0.8 cm (minimum 2.4, maximum -0.1) (Table 1). Thus, continuous breath sound method may determine slightly long length than reality. In the breath sounds changed in continuous breath sound method, gas flow to the left bronchus through the space between the cuff tip and the right bronchial wall decreased, and breath sounds disappeared because the inflated cuff completely sealed the intubated bronchus, interruption gas flow to the opposite bronchus [7]. In other words, absence of a change in breath sounds indicated that ventilation of both lungs was maintained.

References

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