Nasotracheal Intubation – 30.130

INDICATIONS:

A. When definitive airway control is required.
B. Patient has spontaneous ventilations and laryngoscopy is difficult.

CONTRAINDICATIONS:

A. Nasotracheal intubation is not generally recommended in patients who are apneic, who have mid-facial fractures or nasal fractures, or who are suspected of having a basal skull fracture.

PREPERATION:

A. Choose ET tube 1 mm smaller than optimal for orotracheal intubation.
B. Inspect equipment: Suction, laryngoscope, and ETT cuff.
C. Lubricate ETT tube.
D. Pre Oxygenate patient with 100% Oxygen.
E. Monitor SpO2.
F. Determine which naris clearest.
G. Spray Neo-Synephrine spray into naris.
H. Anesthetize naris with Lidocaine jelly 2%.

PROCEDURE:

A. Insert & advance ETT along nasal floor.
B. Anytime the patient goes 30 seconds without ventilation, stop the procedure and ventilate for 30-60 seconds before intubation is re-attempted.
C. If impassable, try the other naris.
D. The curve of the tube should follow the curvature of the anatomy.
E. Gently advance the ETT while rotating it medially 15-30 degrees until maximal air flow is heard through the tube.
F. Swiftly advance ETT during inhalation.
G. Inflate cuff with 5-8 cc of air.
H. Confirm placement by auscultating breath sounds bilaterally.
I. Successful intubation confirmed by bilateral breath sounds, absence of epigastric sounds, positive SpO2 and ETCO2 readings.
J. If attempts fail, withdraw tube, pre Oxygenate and re-direct the ET tube.
K. Secure ET tube
L. Ventilate with 100% Oxygen. Auscultate breath sounds FREQUENTLY

NOTES AND PRECAUTIONS

A. Auscultate breath sounds frequently.
B. Document: SpO2, ETCO2, GCS, lung sounds, absence of epigastric sounds, methods used to verify ETT placement, chest rise, condensation present, ETT depth, naris used.