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Introduction: We present a case during which we preformed nasal intubation with an oral RAE (Ring, Adair and Elwyn) endotracheal (ET) tube in absence of nasal RAE ET tube or conventional ET tube at an international medical mission.

Case report: A 12 years old 35 Kg female presented at the medical mission with post burn injury scar around her mouth and lips, preventing complete closure of her lips. This was leading to constant tricking of saliva, specifically during mastication. Surgeon requested for nasal intubation so that she can match the symmetry of lips while surgical repair. We checked with the medical mission supplies and only different sizes of oral RAE ET tubes were present. After discussing we decided to perform nasal intubation with oral RAE tube for optimizing the surgical outcome. We measured a 6.0mm oral RAE tube externally from her nasal opening to the side on her face, to confirm its cuff and length were long enough to pass beyond the vocal cords with enough tube present at the nasal end to connect to the circuit. A intravenous (IV) access was secured pre induction and standard ASA monitors were applied. After IV induction with propofol and fentanyl, oxymetazoline drops were applied to both nostrils. A 6.0mm oral RAE ET tube was prepared with Lidocaine 1% gel applied. A 14 French suction catheter was used as a guide and placed through the ET. Carefully the leading end of the suction catheter was placed through right nostril while holding on to the posterior end and oral RAE ET tube. As the tip of suction catheter became visible with direct laryngoscopy (DL) in oropharynx, suction catheter was caught with a forceps and ET tube was gently slid down the nostril over the suction catheter as a guide till the tip of oral RAE tube was visible in oropharynx. As oral RAE tube has a pre formed angle, the tracheal end of ET tube was pointing anteriorly and could not slide through the glottis. Carefully suction catheter tip was grasped with forceps and placed though the vocal cords in to the trachea. Then gently 6.0 oral RAE ET tube was slid over the suction catheter while holding on to the posterior end of the suction catheter. The oral RAE ET tube including its cuff slid through the vocal cords easily. Auscultation of bilateral and equal breath sounds with end tidal carbon dioxide waveform confirmed the correct placement of the oral RAE ET tube. After successful completion of surgery patient was extubated in OR without any complications. In recovery room patient did not report any significant pain or discomfort in her naso-pharynx or oropharynx nor any stridor or hoarseness.

Discussion: Nasal intubation for oral surgery places a significant challenge for anesthesiologists. In above given case scenario, absence of nasal RAE endotracheal tube and with limited options we decided to use oral RAE ET tube for securing the airway for surgery. In conclusion an oral RAE tube can be successfully used to nasal intubation for securing the airway.
