Indications:

1. Was used in the past as an alternative to orotracheal intubation because it was considered to be better tolerated when a patient is not completely unresponsive and flaccid. However, in the age of RSI there is no reason to perform nasotracheal intubation unless the oral route is obstructed by injury, swelling, or mass. If such an obstruction exists, consider medications that provide sedation and analgesia. Nasal tracheal intubation will greatly increase ICP. If there is a head injury, consider medication that will blunt a rise in ICP. The risk of epistaxis followed by vomiting and aspiration is high.

Precautions:

1. Patient must be breathing to guide positioning of tube. RSI will terminate spontaneous respirations and take away exhalation as a guide to tube positioning and placement.
2. Trismus must be treated prior to a nasotracheal intubation attempt because, if the procedure induces vomiting, suctioning effectively will be very difficult.
3. Head usually needs to be exactly midline for successful intubation.
4. Have suction ready. In addition to vomiting, bleeding in the posterior pharynx may occur secondary to tube trauma.

Technique:

1. Prepare patient and equipment. A BAAM is helpful. A trigger tip endotracheal is also helpful.
2. Use the largest tube that will fit without trauma. Limitation is nasal canal diameter.
3. Position patient with head in midline, neutral position. Cervical collar may be in place.
4. Preoxygenate well prior to starting.
5. Lubricate ET tube with Xylocaine jelly or other water soluble lubricant.
6. With gentle steady pressure, advance the tube through the nose to the posterior pharynx.
7. A slight resistance will be felt just before entering the trachea. It is helpful to wait for an inhalation before the final advance into the trachea.

Nasotracheal Intubation

8. Continue advancing until air is exchanging through the tube then advance about 1 inch further. Inflate cuff.
9. Ventilate and auscultate over stomach and both lungs. Look for chest rise and fall with ventilations. Use continuous end tidal CO_2 monitoring to verify proper tube placement and ventilatory status.
10. Note proper tube position and tape or tie securely.

Notes

1. The maximum diameter ET tube that will pass through the nare is often smaller than the size tube you would use for an orotracheal placement.
2. Nasotracheal intubation has very few indications if RSI is available.

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