APPENDIX

NASOTRACHEAL INTUBATION

<table>
<thead>
<tr>
<th>CONTRAINDICATIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nasal or upper facial fracture.</td>
</tr>
<tr>
<td>2. Suspected basilar skull fractures.</td>
</tr>
<tr>
<td>3. Generalized head trauma, especially when associated with an obvious skull and/or facial fracture.</td>
</tr>
<tr>
<td>4. Suspected laryngeal fracture or blunt trauma to the anterior neck.</td>
</tr>
</tbody>
</table>

**THE PATIENT MUST BE SPONTANEOUSLY BREATHING**

**PROCEDURE:**

Prepare and check ALS airway equipment as if for routine orotracheal intubation while your partner ventilates the patient with 100% oxygen by bag-valve device at a rate of 8-10 bpm with visible chest rise.

Inspect the nares to determine whether there is any septal deviation, mucosal hypertrophy, or any other factors that may render one side more patent than the other.

1. Prior to nasal intubation, start an IV and administer 100 mg Lidocaine IVP if suspected ICP. With the patient’s head in a neutral in-line position, inspect the nostrils while the patient receives 100% oxygen. Select the appropriate tube size, lubricate the distal end, and prepare to insert the tube.

2. Advance the tube into the larger nostril, guiding it in an anterior to posterior direction.

**NOTE:** Advancing the tube superiorly will commonly result in increased resistance and potential injury at the turbinates.
APPENDIX

NASOTRACHEAL INTUBATION - cont’d

3. As the tube is advanced into the pharynx, listen closely at the end of the tube for the patient’s breath sounds and watch for misting of the tube. When breath sounds are loudest, wait for the next inhalation and gently pass the tube into the trachea. If the patient is conscious, ask him to take a deep breath and pass the tube into the trachea during inhalation. As the tube is passed through the vocal cords, the patient may begin to cough, however, the cords will remain open during the cough and the tube can be easily inserted into the trachea.

4. If the first attempt is unsuccessful, pull the tube back slightly and attempt once more, listening for the patient’s breathing. (One trick is to remove the head (diaphragm bell) from your stethoscope, and placing the stethoscope tubing down the ET tube, listen for the breath sounds through your stethoscope).

5. Once you believe the tube is properly placed, auscultate over epigastrium and all four chest quadrants to confirm placement.

6. Inflate the cuff with 5 to 10 cc’s of air and appropriately secure the tube in place.

7. Repeat auscultation of the epigastrium and chest quadrants frequently to reconfirm proper positioning.

PRECAUTIONS:

1. The same precautions apply to nasotracheal intubation as apply to orotracheal intubation. A stylet is not recommended because of the technique utilized in nasotracheal intubation.

2. If a basilar skull fracture is suspected, nasotracheal intubation is best deferred until the patient is in the hospital.

3. Injury to the nasal mucosa and subsequent epistaxis is a common complication. Nasal intubation can also break the mucosa in the posterior nasopharynx and dissect submucosally into the pharynx with possible, subsequent infection.