

Transtracheal ventilation

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This technique is simple and effective and allows ventilation for periods in excess of 1 hour, providing time to allow for more elective intubation. The cricothyroid membrane is located as discussed above, and a 14- or 16-gauge plastic sheathed intra vascular needle attached to a 10-mL syringe containing a few millilitres of lidocaine is introduced in the midline and directed downwards and backwards into the tracheal lumen. The needle is advanced steadily and negative pressure is placed on the syringe until bubbles of air are clearly seen (Figure 52.48 The tissues of the neck may be infiltrated with the anaesthetic if desired and the tracheal mucosa likewise partly anaesthetised by the introduction of 1–2 mL of lidocaine after gaining the lumen. The needle is removed and the plastic sheath cannula left in the tracheal lumen; it must be carefully held and fixed in place by the operator so that it does not come out of the lumen into the soft tissues of the neck. It is attached by means of a Luer connection to the high-pressure oxygen supply . Ventilation may be undertaken in a controlled manner with a jetting device, with the chest being observed for appropriate movements. If there is severe obstruction of the laryngopharynx by the foreign body or tumour, the exhaled outflow of gases can Hermann Adolph Wülfing-Lüer , 1836–1909, German instrument maker who was working in Paris, France, at the end of the nineteenth century . exhalation ports. This procedure gains extremely rapid control of ventilation and requires a minimum of technical expertise. Its only notable complication is surgical emphysema of the neck tissues if the cannula dislodges from the tracheal lumen. Transtracheal ventilation

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