

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.