



Strategies to Improve First Attempt Success at Intubation in Critically Ill Patients

Jennifer M. Hunter*

Department of Ageing and Chronic Disease, University of Liverpool, UK

INTRODUCTION

Intubation is a procedure in which a healthcare provider inserts a tube into a person's windpipe (trachea) through the mouth or nose [1]. The tube keeps the trachea open and allows air to flow. The hose can be connected to a machine that supplies air or oxygen. Medicines that "put you to sleep" (general anesthesia) during surgery may also slow breathing. Intubation allows the machine to breathe for you [2]. For this reason, anesthesiologists (doctors who put patients to sleep for surgery) may intubate them. Your doctor may also do this if you have an injury or illness that makes breathing difficult. This is because breathing provides all the cells in your body with the oxygen they need [3]. If you don't get enough, you can pass out, have brain damage, or even die. Ventilation also helps you exhale. This facilitates the excretion of CO₂, so that he does not accumulate CO₂ in his blood and become acidified (respiratory acidosis) [4]. This can lead to other health problems. Even if you seem to be breathing normally and your blood oxygen levels seem fine, you may need to be intubated [5]. Since you are unconscious, your doctor may want to do that.

DESCRIPTION

An illness or injury may be deteriorating rapidly or weakening airway reflexes. If you need emergency surgery that requires general anesthesia, your doctor can intubate you [3]. In this case, I wasn't fasting to empty my stomach like I was in a planned surgery [1]. Food from the stomach can enter the lungs when vomiting or regurgitating from the stomach (aspiration). To prevent this, the tube has an air bladder that inflates to seal the airway from the stomach [5]. In some cases, health care practitioners may decide that intubation is unsafe. If there

is severe airway trauma or an obstruction that prevents safe placement of the tube [2]. In such cases, a healthcare provider may decide to surgically open an airway through the throat at the base of the throat. This is called a tracheotomy. A tracheotomy is often necessary if an endotracheal tube is in place for more than a few days or even weeks. Intubation rarely causes problems, but it can happen [4]. The endoscope may damage your teeth or cut inside your mouth.

CONCLUSION

The tube may injure the throat and vocal cord, causing a sore throat and difficulty speaking and breathing for some time. This procedure can damage the lungs or cause one of them to collapse. Infections and pneumonia can also occur. You may be more likely to experience these issues. If you have just eaten, you risk inhaling the food into your lungs. Poor tooth condition increases the chances of the scope damaging the tooth. Intubation and recovery may be more difficult if you smoke, have a lung condition like COPD, have a neck or spine injury, or are overweight.

ACKNOWLEDGEMENT

None.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

REFERENCES

1. Simpson GD, Ross MJ, McKeown DW, Ray DC (2012) Tracheal intubation in the critically ill: A multi-centre national study of practice and complications. Br J Anaesth 108(5):

Received:	01-November-2022	Manuscript No:	IPJICC-22-15134
Editor assigned:	03-November-2022	PreQC No:	IPJICC-22-15134 (PQ)
Reviewed:	17-November-2022	QC No:	IPJICC-22-15134
Revised:	22-November-2022	Manuscript No:	IPJICC-22-15134 (R)
Published:	29-November-2022	DOI:	10.35248/2471-8505.22.8.110

Corresponding author Jennifer M. Hunter, Department of Ageing and Chronic Disease, University of Liverpool, UK, E-mail: jm_hunter@liverpool.ac.uk

Citation Hunter JM (2022) Strategies to Improve First Attempt Success at Intubation in Critically Ill Patients. J Intensive Crit Care. 8:110.

Copyright © 2022 Hunter JM. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

792-799.

2. Mort TC (2004) The incidence and risk factors for cardiac arrest during emergency tracheal intubation: Justification for incorporating the ASA guidelines in the remote location. *J Clin Anesth* 16(7): 508-516.
3. Hagiwara Y, Watase H, Okamoto H, Goto T, Hasegawa K, et al. (2015) Prospective validation of the modified LEMON criteria to predict difficult intubation in the ED. *Am J Emerg Med* 33(10): 1492-1496.
4. Mallampati SR, Gatt SP, Gugino LD, Desai SP, Waraksa B, et al. (1985) A clinical sign to predict difficult tracheal intubation: A prospective study. *Can Anaesth Soc J* 32(4): 429-434.
5. Schmidt UH, Kumwilaisak K, Bittner E, George E, Hess D (2008) Effects of supervision by attending anesthesiologists on complications of emergency tracheal intubation. *Anesthesiology* 109(6): 973-977.