

Endotracheal Intubation Challenges to Oral Cavity – Prevention Strategy

Sir,

Emergency endotracheal intubation and less experienced staff probably increase the chance of traumatizing hard and soft oral tissues. Intraoral manipulation is necessary during general anesthesia involving endotracheal intubation during many craniofacial and maxillofacial surgeries. With reference to an excellent article published in your esteemed journal regarding treatment of Vallecular Cyst Using Conventional Laparoscopic Instruments,^[1] I would like to add some vital information regarding endoscopic intubation challenges. Although laryngoscopy is a safe procedure and complications rarely occur, intraoral manipulation can produce damage to soft and hard tissues of the oral cavity, patient discomfort, and postoperative pain.^[2,3] In Pediatrics, the more frequently studied lesions occurred during placement of the tracheal tube are dental traumas, with an incidence ranging from one case in 150 intubations to one in 2805 intubations.^[4] In addition to forceful intubation or extubation, vigorous suctioning of posterior teeth, pressure-induced damage to the adjacent tissues by insertion of the laryngeal mask airway (LMA), masseteric spasm derived by hypothermic-induced shivering and biting forces against antagonist teeth or endotracheal tube (ETT) should all be taken into account. Hence, intubation, extubation and suctioning should be performed with great care. If the child has a loose tooth and avulsion or aspiration is deemed, a careful suturing of the affected tooth to the adjacent sound tooth just around the crown of the teeth may prevent avulsion and aspiration.^[5] During the preoperative assessment, the anesthetist should enquire about loose teeth, unstable crowns, veneers, bridgework and any intra-oral prostheses (dentures or orthodontic appliances). The patient should be warned about the potential for dental damage and its incidence, and any particular risk factors, either anesthetic or dental, should be identified and explained to the patient. Following an incident of perioperative dental damage, the goal is to obtain an immediate assessment and provide a fair

reimbursement for treating the injury. More detailed and comprehensive teaching courses for subspecialty fellows or nurses involved in critically ill pediatric patient care may warrant more professional insight into the different stages of dentitions, endotracheal intubation complications concerning hard and soft oral tissue damages and management options for when traumatic injury happens. The above-mentioned details could help an oral surgeon and anesthetist in overcoming any dental hazards and a promising treatment pattern during surgery.

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