In Response to Removal of Obstructing T-Tube and Stabilization of the Airway

In Reply:

I appreciate the opportunity to respond to the letter to the editor authored by Dr. Jeremy Richmon regarding our recently published instructions for dealing with T-tube obstruction.1 I also appreciate that Dr. Richmon’s expressed views exemplify issues with the current state of education on airway management in otolaryngology.

First, I would like to comment directly on Dr. Richmon’s specific views of the instructions that we outlined in our initial article. Dr. Richmon is doubtful that a patient in acute airway obstruction has the ability to grasp and pull out their T-tube and is concerned that they could make the situation worse because he believes that inserting a tracheostomy tube is “a complex maneuver.” On the contrary, we have seen that even a partially obstructed tube can become fully obstructed within minutes. In the case of a significantly obstructed or fully obstructed tube, the tube is essentially nonpatient, and grasping the outer limb with a clamp cannot make a life-threatening situation worse as suggested by Dr. Richmon. Although not included in our published article, the technique described has been used by at least two of our patients who were able to remove the tube themselves because they realized the gravity of the situation. In addition, contrary to the views expressed by Dr. Richmon, these patients had no difficulty inserting a standard tracheostomy tube following self-removal of their T-tube and were then able to be managed in a nonurgent manner.

Anecdotally, within 1 month of the publication of our guidelines, a former colleague contacted me to express his gratitude for giving him a resource to distribute to his emergency department colleagues after a patient presented to his hospital with their T-tube obstructed, requiring emergent removal by one of his otolaryngology residents. A second colleague reported that at her institution, they had two deaths in the emergency department because the otolaryngology resident could not get there soon enough after the patients initially obstructed at home. Dr. Richmon may have concerns with our methods, but I would ask him to suggest an alternative action for the acute management of a patient with T-tube obstruction. Although we agree with Dr. Richmon when he concludes that proper education and prevention is the best approach to managing airway tubes, one cannot argue that even the most educated and compliant patients may develop obstruction in the presence of upper respiratory infections or due to other factors, and this highlights the critical need for patient education on the safe and reliable management of their T-tube.

We also respectfully disagree with Dr. Richmon’s expressed view that inserting a tracheostomy tube into a mature stoma is “a complex maneuver that requires dedicated training by nurse educators and respiratory technicians.” Routine tracheostomy tube insertion should not be thought of as a complex maneuver, and statements to the contrary can be very dangerous to patients. As Dr. Richmon correctly states, not all practices need scientific evidence to support them. Tracheostomy care is one of these practices. In my 17 years of practice, I have witnessed over and over the failure of proper patient education in what should be routine tracheostomy care. Patients are often discharged following tracheostomy without appropriate education on management and without follow-up. Patients are routinely being seen in our practices with the same tube in place for several months, some with a cuffed tube still in place. This is substandard practice and results in part from a failure in the education of our residents. It is our opinion, based on our experiences, that every patient with a tracheostomy should be taught on discharge or at their first postoperative visit how to remove and change their tube on a routine basis. We have found that this practice results in a cleaner stoma with less granulation and friability as well as improved patient confidence in managing their tube and stoma.

T-tubes are inherently dangerous and in most cases are used as a last resort in most patients. However, T-tubes, and tracheostomy tubes for that matter, should not be feared by the clinician or the patient. Proper education of our residents and our patients will help achieve this goal. Given a potentially life-threatening situation, we believe that most patients will be able to perform the described procedure and firmly believe that our published recommendations for managing T-tube obstruction will improve patient outcomes.

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BIBLIOGRAPHY