Tracheal & Thoracic T-Tubes

Patents Applied

IMPORTANT - Do Not Discard

Post-Placement Care Instructions for the Patient with a T-Tube. A Healthcare Professional should review with patient and family or caregiver before discharge.

Hood T-Tubes are designed to maintain patency of the tracheal airway and to provide respiration through the larynx. They allow phonation and provide support in the management of acute tracheal injury.

The T-Tube plug, which is inserted in the external, horizontal limb and secured by a slight twist, is held in place by friction. The plug stays in place in order to allow for normal respiration and phonation. Hood Tracheal T-Tubes are designed with the stopper plug attached to the extraluminal limb to ensure most secure placement and to offer extra convenience in daily cleaning and maintenance. The Flanged Plug can be detached and threaded over the extraluminal limb to fit snugly against the patient's tracheostoma for added long term security. The Tracheal T-Tube with Rings is supplied with a ring that is separate from the T-Tube. The ring is threaded over the patient's tracheostoma.

The intraluminal portion of the tube is sufficiently dense and thick to support reconstituted or stenotic trachea, and sufficiently soft to preclude injury to mucosa or supporting structure of the trachea.

The portion of the tube which projects from the tracheostomy orifice is smaller in diameter than the intraluminal portion, with a substantial internal radius and outside diameter at the junction. The internal radius aids in the insertion of a catheter for suctioning and cleaning, while the outside diameter provides molding support for the reconstructed trachea. The external portion of the tube can be tilted to insert suction catheters inferiorly or superiorly.

The flexible, non-irritating material causes little tissue reaction and prevents hardening of the T-Tube even after prolonged contact with body temperatures and secretions. The ends are tapered so asynchronous motion between the tube and mucosa will not cause injury. Mucus and crusts do not readily adhere to its rounded surfaces when the side arm is kept plugged.

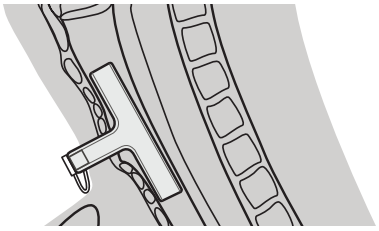
Maintenance and Hygiene

Post-placement care is vital in the management of patients with a T-Tube. The T-Tube must be kept patent and clean. Review tips below.

Useful Tips

- **At home, patients will benefit from a room humidifier, especially in the bedroom.**
- **To avoid losing the plug, patients may pass a thread through the plug, make a loop and tie it around their neck, or pin the loop to their clothing.**
- **Patients should have an extra tracheostomy airway with them.**
- **The T-Tube stem should be plugged at all times (as long as the condition can be tolerated).**

Fig. 1
T-Tube in place with silicone plug inserted



Post-Placement Care Instructions

WEEK 1

1. Keep a small tracheostomy airway at patient's bedside for physician use and for emergency insertion.
2. Administer antibiotics, per physician's order.
3. Plug the external limb to the T-Tube when the patient has recovered from the anesthesia, if possible. Unplug it for any respiratory distress. Replug when able. There is the potential for post-op upper airway edema if the upper end of the tube is against vocal cords.
4. Constant humidity is essential in the post-op period to keep secretions moist and to help raise secretions. It may be necessary to remove the plug and apply humidity directly over the external opening. Use a face mask if the tube is plugged. Use a tracheostomy mask if the tube is unplugged.
5. Instill saline 3 times per day to prevent or dislodge crusting within the T-Tube.
6. **Perform skin care 3 times per day**. Clean the skin around the external portion of the T-Tube with a cotton-tipped applicator (Q-Tip) dipped in 1/2 strength hydrogen peroxide. Apply Povidone iodine ointment after cleaning with hydrogen peroxide.
7. **Clean the external arm of the T-Tube**. Clean inside the T-Tube with Q-Tips dipped in 1/2 strength hydrogen peroxide. Finish cleaning with dry Q-Tips.

Post-Placement Care Instructions

AFTER 1st WEEK

1. Continue plugging the external arm of the T-Tube. Mask humidity is not necessary as normal respiratory mechanics will keep the T-Tube and secretions moist.
2. Instill saline 2 times daily (see Procedure for Instillation of Saline, below).
3. **Perform skin care, 2 times daily** (same as week one).
4. **Clean the external arm of the T-Tube 2 times daily** (same as week one).

Procedure For Instillation of Saline

(A mucolytic agent may also be prescribed by the physician.)

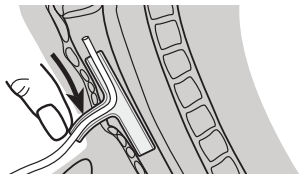
1. Unplug the T-Tube.
2. Instill 1/2-1cc of saline. **Never use a syringe with the needle attached when instilling**.
3. Plug the T-Tube and have the patient cough to clear secretions. The patient may require suctioning at this time (see Procedure for Suctioning on page 2).
4. Instill 1-3cc normal saline. Repeat Step 3.

Procedure for Suctioning

Remove plug and suction:

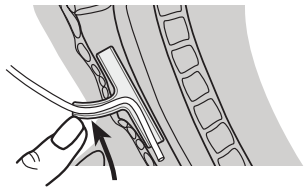
Upwards: The suction catheter is directed up the intraluminal tracheal limb of the T-Tube by bending the extraluminal limb down (**Fig. 2**).

Fig. 2



Downwards: The suction catheter is directed down the intraluminal tracheal limb of the T-Tube by bending the extraluminal limb up (**Fig. 3**).

Fig. 3



It is not necessary to insert the suction catheter any great distance beyond the ends of the T-Tube. This only produces irritation of the tracheal lining and coughing. Deep suction only if the patient's condition warrants.

The actual length of time that the device is left in place will depend upon the surgeon's judgement. Removal after a maximum of 29 days is recommended.

References:

Montgomery, W. W.,
"Surgery of the Upper Respiratory System." Vol. 2, published by Lea and Febiger, Philadelphia and Henry Kimpton Publishers, London, 2nd ed., 1989.

The editorial review and approval of these instructions by Ruth Dempsey, R.N., Head Nurse at the Department of Thoracic Surgery, Massachusetts General Hospital, are gratefully acknowledged.

It is important this information is reviewed with patient before discharge.

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