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AN URGENT TRACHEOTOMIA

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Tracheotomia is a largely spread intervention in the field of respiratory tracts and is required in a variety of pathological conditions. Indications for tracheotomia after Bisalski are:

1. Mechanically obstructed respiration
2. Respiration disorder of central origin
3. Bronchopulmonary disorders of respiration
4. Preventive indications for tracheotomia

Tracheotomia is refered to the complicated surgical interventions especially concerning dyspnoe patients and children, it is often accompanied by complications, including lethality.

A lot of surgeons prefer to make tracheotomia after preliminary intubation of the patient when the condition of urgency drops off. There are opponents when carcinoma laryngis is concerned who are based on oncological and anaestesiogical point of view.

Most adequate, concerning carcinoma laryngis, is a lower tracheotomia which does not allow a trauma of the thyroid gland and allows a typical laryngectomia after that to be held. In the present study our aim is to analyse the urgent tracheotomias in our Clinic for the period from 1980 to 1990 and the problems which are to be sold in this dramatic situation.

For this period 183 tracheotomias were held in urgency in the Clinic. Of them, 176 were because of carcinoma laryngis, 2 - of laryngospasmus, 1 - of carcinoma lingue, 2 - of carcinoma hypopharyngis, 2 - of tumors of the thyroid gland. We surveyed an exitus lethalis of a carcinoma laryngis who arrived in asphyxia. Usually, patients came into the Clinic with a respiratory insuficiency of II-III stage. It is a very stress situation (the urgent tracheotomia) when, in a limit of time, a supply of oxygen has to be delivered, a team with a good surgical technique has to be formed including anaestesiologist-reanimator.

We made tracheotomia under local anaestesia with a 1% Lidocain. Only 5 tracheotomias were made to preliminary intubated patients, but the rest almost always in the presence of an anaestesiologist-reanimator who observed the vital indications of the patient, the oxygen delivery and an eventual intubation. When the situation is urgent and

topographo-anatomical difficulties are available his presence contributes to calm the surgeons' work. The difficulties which occur in an urgent tracheotomia are also due ro the compulsory location of the head which cannot be extended. An upper tracheotomia and a medium one were made only when there was a great isthmus of the thyroid gland and of patients with picnic habitus and a short neck.

Another question is whether the urgent tracheotomia in connection with carcinoma laryngis should be permanent or not tracheostoma. As most patients are inoperatable we resume a permanent tracheostoma to be made which facilitates the postoperation period to be held.

A considerable number of patients come into Clinic without a preliminary biopsia. We prefer to take biopsia on the third or the fourth day after the tracheotomia when have a possibility to make a good examination in a calm atmosphere.

We have surveyed the following complications: subcutaneous emphysema - 10, a result of the discrepancy between the opening in the trachea and the size of the canula; unilateral pneumothorax - 1; bleeding - 1. As a reason for the complications we should point out the unfavourable conditions under which the tracheotomia is held, the topographo-anatomic variant of the cervix, the state and the age of the patient, the wrong selection of the canula size and the cutting in the trachea.

The postoperative treatment of the tracheotomia patients is extremely important for preventing suppuration of the wound, development of tracheitis and tracheobronchitis. Every treatment should be held under aseptic conditions with aspiration in periods of 40-50 min at the beginning, with dropping trypsin or physiological saline.

In order an urgent tracheotomia to be held most effectively, technically and with the less possible complications we assume it is necessary:

1. Very well organised treatment of the patient and assessment of the stage of dyspnoe.

2. An anaestesiologist-reanimator to be present because the urgent tracheotomia is connected with considerable difficulties.

3. If possible - lower tracheotomia regarding the habitus of the patient and the urgence of intervention with choice of proper canula.