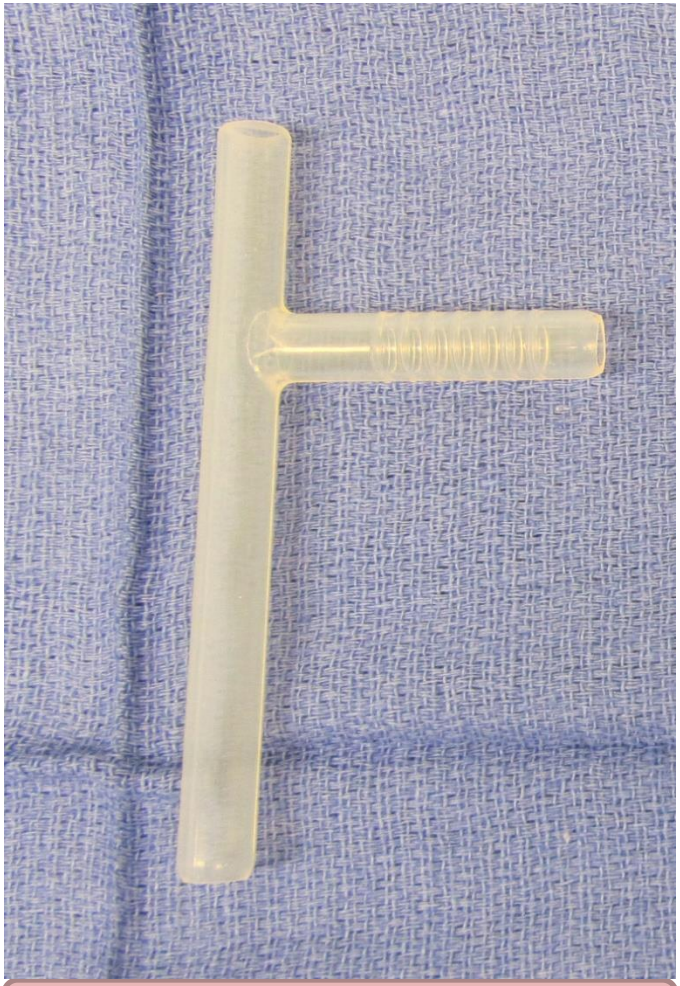
Management of T-Tubes

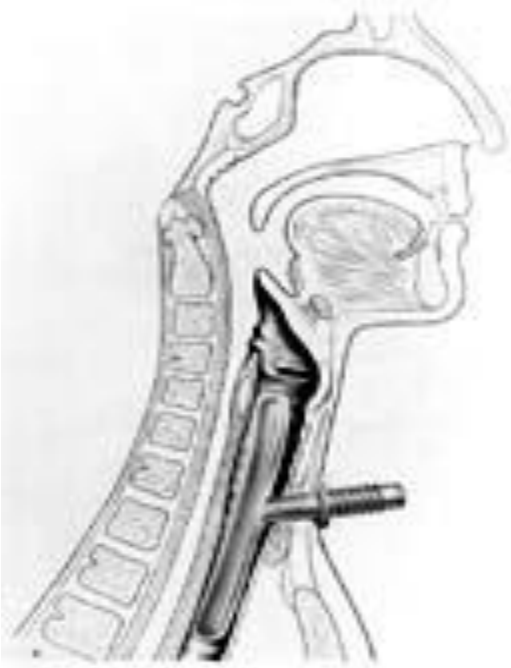
What is a Tracheal T-tube?

- Tracheal T-tube is a tracheal airway stent made of silicone and shaped liked the letter “T”
- It maintains an adequate tracheal airway, while providing support of a stenotic trachea that has been reconstituted or reconstructed
- Comes in various sizes
  - Most commonly used sizes at UCLA are #10 for women and #11 for men

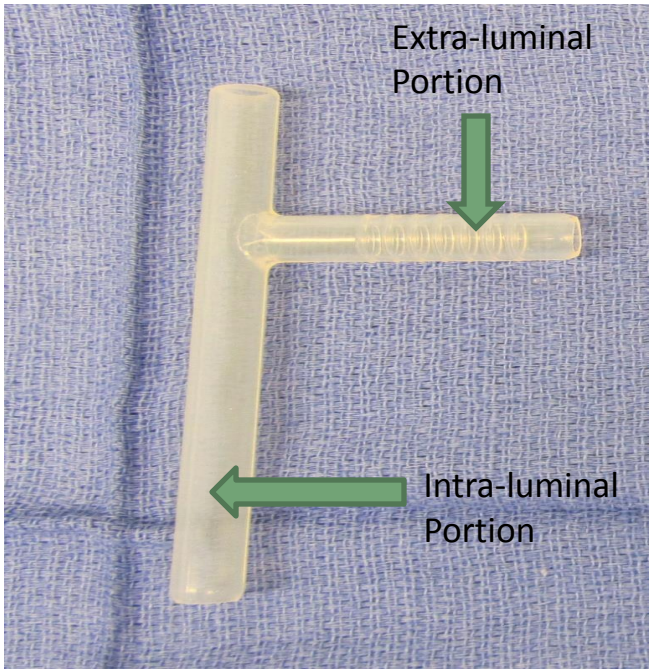


Tracheal T-Tube

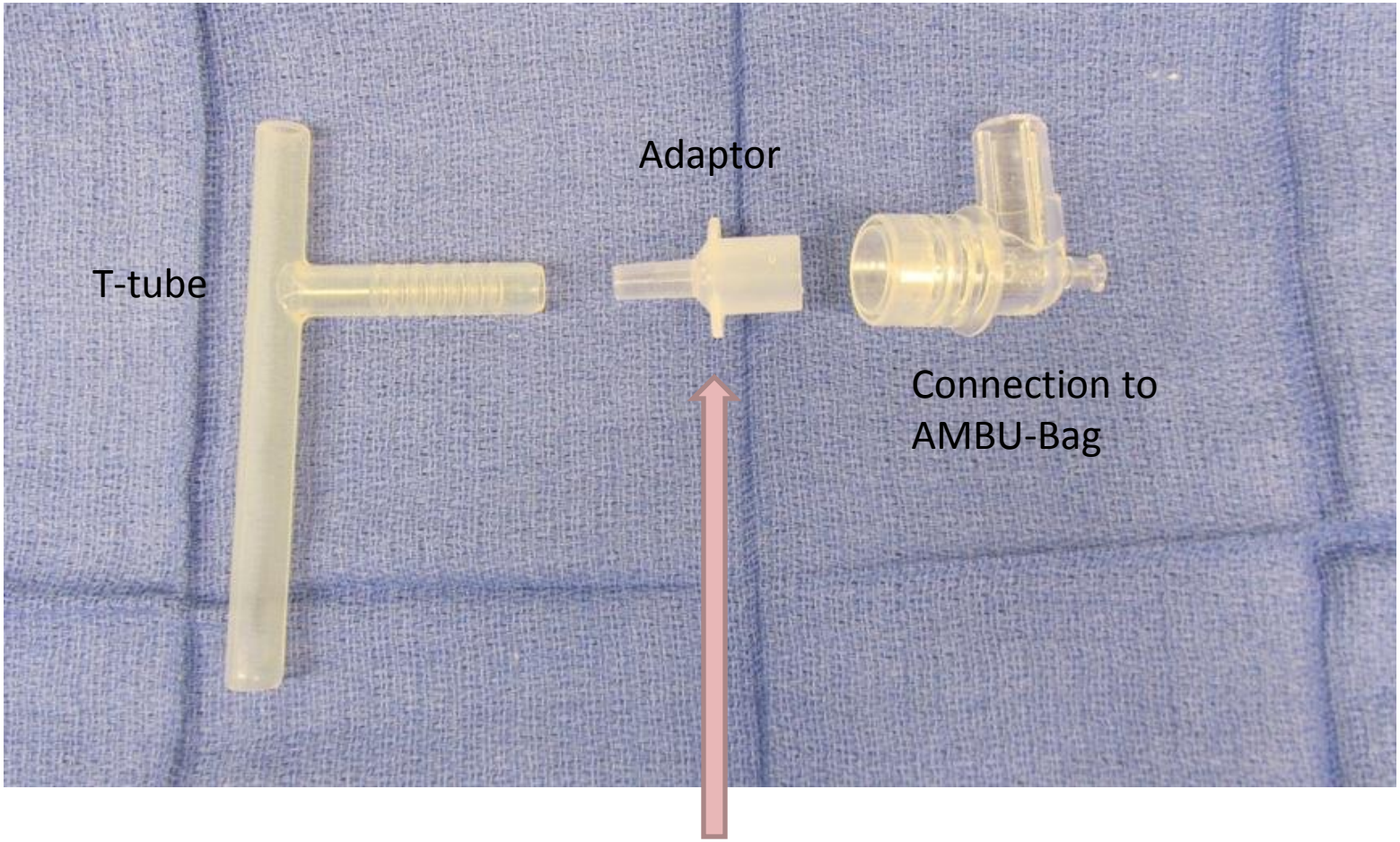
Other Features of T-tubes



- Serves as both a stent, to prevent airway collapse, and a tracheostomy tube, for breathing
- Because it is made of silicone, it initiates little to no tissue reaction
- Extra-luminal end can be plugged so speaking and breathing through the nose and mouth is possible while the T-tube stent is in place
- Mucus and crusts in general do not adhere to the silicone. HOWEVER,
  - T-tube does NOT have an inner cannula and mucus plug prevention is important
  - Regular suctioning and keeping the tube capped is key to mucus plug prevention
  - In case of significant mucus plug the T-tube may need to be removed.

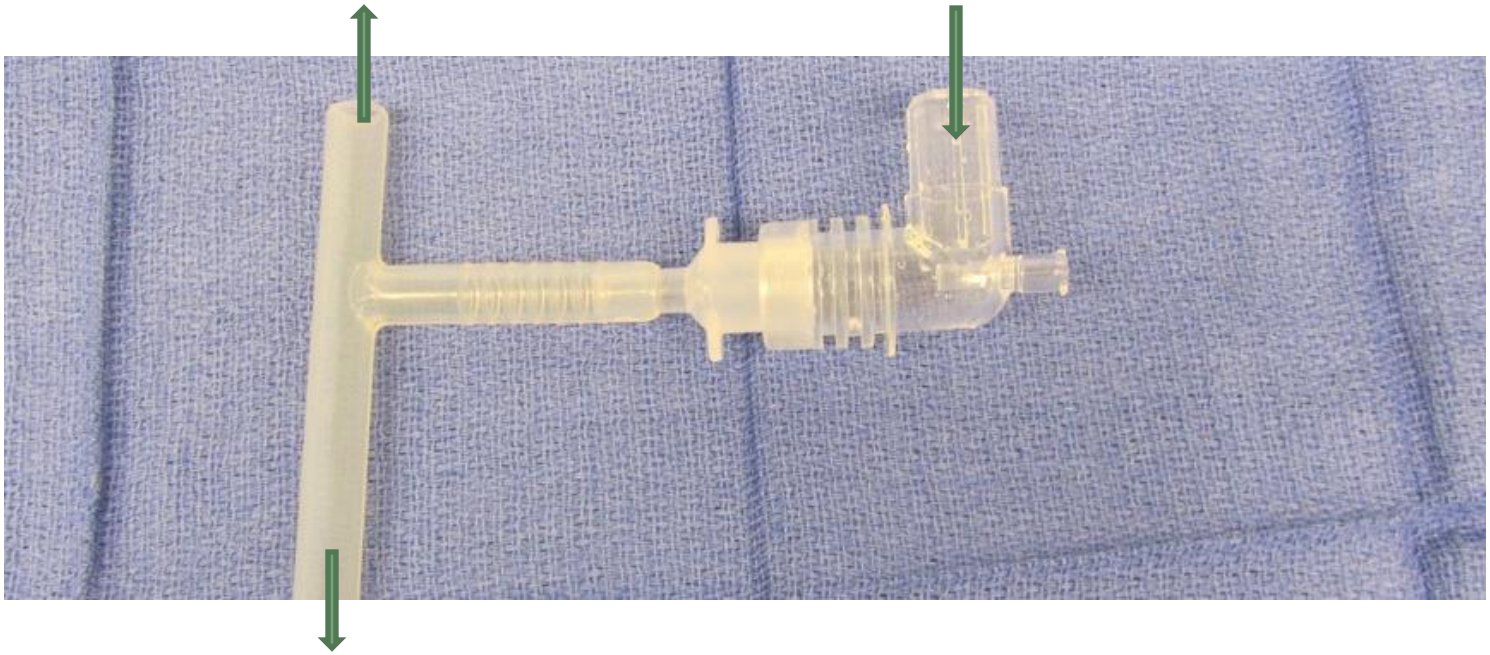


Ventilating Through T-tubes



For a #10 T tube → Can get adaptor from 5.5 Endo-tracheal Tube (ETT)
For a #11 T tube → Can get adaptor from 6.5 ETT

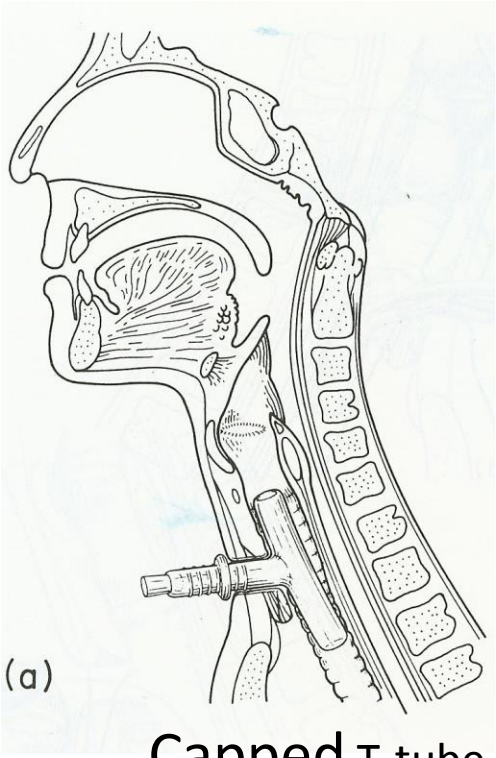
Ventilating Through T-tubes



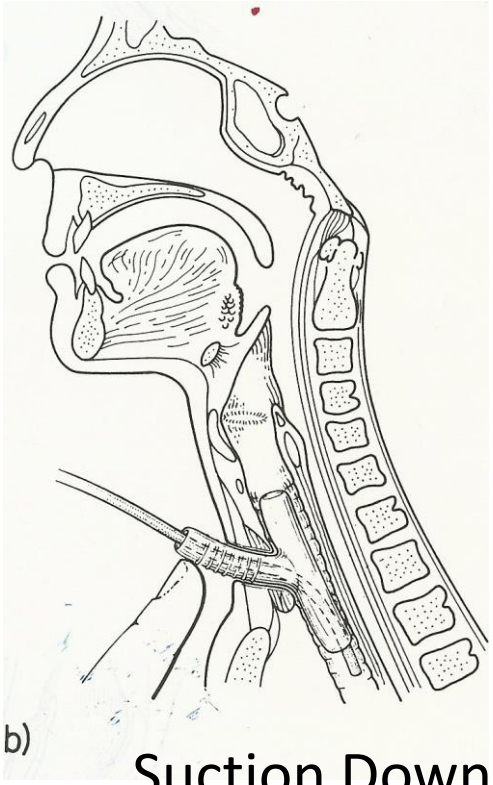
Note that when Ambu-bagging a patient via a T-tube, airflow is directed both towards lungs and mouth. Pinching both nostrils and closing mouth will direct more airflow towards lungs. (Arrows in figure show direction of airflow.)

Ventilating through T-tubes

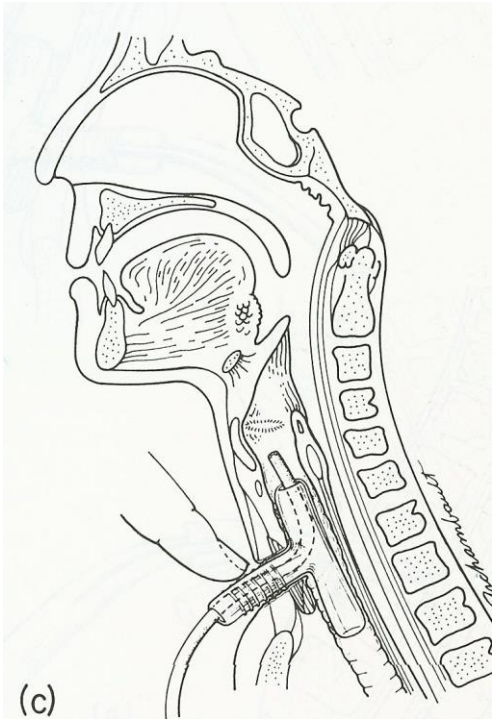
Suctioning T-tubes



Capped T-tube



Suction Down



Suction Up

The external portion of the T-tubes should be directed up to suction down towards the lungs.
The external portion of the T-tube should be directed down to suction up towards the vocal cords.