Endobronchial Intubation: A Preventable Complication

ROBERT L. OWEN, M.B.A., R.R.T.,* FREDERICK W. CHENEY, M.D.†

A major complication of endotracheal intubation is accidental migration of the tube tip into a mainstem bronchus. If unrecognized, endobronchial intubation can lead to hypoxemia secondary to collapse of the contralateral lung and hyperinflation of the intubated lung with resultant tension pneumothorax. In the ICU setting, poor radiographic placement relative to the carina has been reported in a number of studies,1–7 with a significant increase in morbidity due to right mainstem intubation reported in one.1 The standard bedside method for diagnosis of endobronchial intubation is bilateral auscultation of the chest. This is not always satisfactory, as breath sounds can be transmitted to the opposite side of the chest in the presence of endobronchial intubation.7

We designed a study to test the hypothesis that proper placement of the tip of an oral endotracheal tube with respect to the carina could be accomplished by referencing the measurements printed on the tube’s side.

METHODS

We studied 578 adult patients admitted to our 22-bed multidisciplinary adult Critical Care Center (CCC). There were 388 men and 190 women entered into the study. The majority of these were postoperative open heart patients who had been intubated in the operating room. A few endotracheal intubations were performed elsewhere in the hospital on a more emergent basis. Of this total, 304 were assigned to the study group and 263 to the control group. We arbitrarily defined the “normal range” of height as 168–184 cm in males and 158–174 cm in females.8 Data collected on patients whose height fell outside of these ranges was excluded.

In the study group, endotracheal tubes in men were positioned at the 22-cm mark measured at the upper incisor teeth, and women had their endotracheal tubes positioned at the 21-cm mark.9 Endotracheal tubes in endotracheal intubation of the CCC were similarly positioned, using the upper anterior gums as reference. The endotracheal tubes of all study group patients were positioned immediately after their admission to the CCC by respiratory therapists prior to the initial post-intubation chest radiograph.

Patients enrolled in the study were initially intended to be randomized into either the study or control groups. However, patients randomly assigned to both groups began arriving in the ICU from surgery with their endotracheal tubes correctly pre-positioned according to the study group protocol. The anesthesia housestaff, informed of our project, began placing the tubes of all patients according to our experimental protocol, thus skewing the results. In order to avoid bias, we then reviewed historical records and chest radiographs of all patients who had been admitted to the CCC the previous year.

In evaluating endotracheal tube position relative to the carina, no attempt was made to correct the measured distance for radiologic magnification. The radiograph was always taken anterior-posterior with the patient in the supine or semi-recumbent position, and no attempt was made to standardize the head position as the radiograph was taken. Of the 578 patients enrolled, 11 were excluded due either to poor visual clarity of the film or because the patient fell outside of our predetermined height parameters. We used Goodman’s criteria, according to which the ideal position of the endotracheal tube within the trachea is 5 ± 2 cm (mean ± SD) from the carina. This radiographic measurement was uncorrected for magnification, and made with the head in the neutral position.

Continuous variables were summarized as mean ± SD and range. Student’s unpaired t test was used to compare means. Frequency histograms of endotracheal tube positions were

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TABLE 1. Patient Height

<table>
<thead>
<tr>
<th></th>
<th>National Average</th>
<th>Control Group</th>
<th>Study Group</th>
<th>Range: Control and Study Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>172 cm</td>
<td>175 ± 4 cm</td>
<td>173 ± 4 cm</td>
<td>168-184 cm</td>
</tr>
<tr>
<td>Women</td>
<td>162 cm</td>
<td>165 ± 3 cm</td>
<td>162 ± 3 cm</td>
<td>158-174 cm</td>
</tr>
</tbody>
</table>

Mean values ± SD for patient height in control and study groups.

The tips of the endotracheal tubes tended to be placed higher in the trachea in the study group. Eighty-three patients in the study group (27%) and 19 patients in the control group (7%) had the end of the endotracheal tube 7 cm or higher from the carina (P < .001). In spite of the higher placement in the study group, the endotracheal tube cuff did not impinge on the vocal cords of any patient by radiograph, nor were there any accidental extubations.

**DISCUSSION**

Positioning an oral endotracheal tube by referencing the marks on the side of the tube would seem to be a better method of preventing endobronchial intubation than auscultation of the chest, which was presumably performed in the control group by the individual intubating the patient. In addition to the seven patients in the control group with endobronchial intubation, eight others, who had the tip of the endotracheal tube closer than 2 cm from the carina, would also be at very high risk for this complication (fig. 1). Conrardy et al.\(^\text{10}\) reported that neck flexion from a neutral head position can advance the tube up to 3.1 cm toward the carina (mean = 1.9 cm). If patients with the end of their oral endotracheal tubes closer to the carina than 3 cm are considered at high risk for endobronchial intubation, then 35 patients were at risk in the control group, compared to only two patients in the study group (fig. 1).

The risks of assessing proper placement of oral endotracheal tubes by the criterion used in this study seem to be mainly that of leak from the placement of the cuff between the vocal cords or accidental extubation. In no case in the study group was the cuff noted to be at the level of the vocal cords by x-ray, and subsequent migration of the cuff between the cords would be easily recognized by the presence of an air leak with positive pressure ventilation. Although the tip of the endotracheal tube has been reported by Conrardy et al.\(^\text{10}\) to move up to 5.2 cm away from the carina with neck extension from neutral head position, we did not experience any accidental extubations. Our failure to observe problems with higher tube placements in the study group may be related to the fact that there was a tendency for the patients' heads to be in extension during the performance of the portable chest radiograph in the CCC. Thus, the radiograph may have been taken with the tip of the endotracheal tube in a higher position than it would have been after the film plate had been removed.

The results of this study can be applied in both the operating room and in the intensive care setting. In case of development of sudden hypoxemia in an intubated patient in the operating room or intensive care unit, a rapid assessment of the likelihood of endobronchial in-

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**Fig. 1.** Distance of the oral endotracheal tube tip from the carina in control and study groups.
tubation as the cause can be made by checking the centimeter markings on the side of the tube. If endotracheal tube placement is the only indication for a chest radiograph, then it would seem an unnecessary expense if the tube has been secured as we describe in the average-sized adult. A portable chest radiograph costs approximately $82 at present in our institution, so the savings are not trivial.

Finally, the question arises as to the proper method of positioning the endotracheal tube relative to the carina in patients whose body length does not lie within the average adult range. Dornette has described an anatomical method for determining placement of the endotracheal tube which can be used for either oral or nasal intubation. The endotracheal tube is placed alongside the patient’s face and neck with the tip of the tube lying at the suprasternal notch. The tube is aligned to conform externally to the position of a nasal or oral endotracheal tube. The centimeter markings at which the tube intersects with the teeth or gums (oral intubation) or the nare (nasal intubation) are noted, and the tube secured in that position after intubation. This is the method we utilize in adult patients whose body lengths lie outside the normal range.

In summary, we have shown that securing oral endotracheal tubes at the upper incisor teeth or gums at the 23-cm mark in men and the 21-cm mark in women of average adult size significantly reduces the likelihood of inadvertent endobronchial placement of an endotracheal tube.

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Use of Midazolam Infusion for Sedation following Cardiac Surgery

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A major challenge after cardiac surgery is to provide adequate sedation, analgesia, and hemodynamic stability without prolonging recovery time. Determining the

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