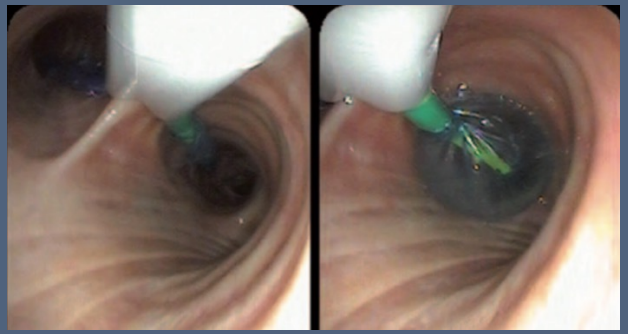
Lung Isolation – Best Practice Wiki

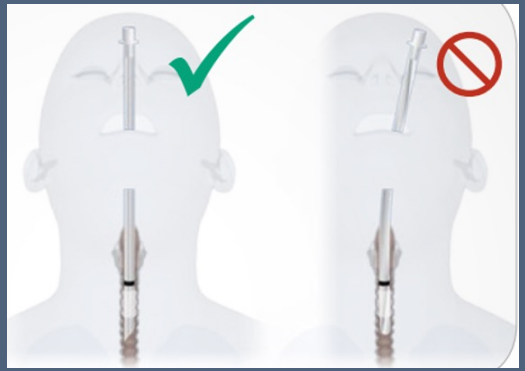
EZBB Issues

- The “Y” of the blocker needs 4 cm of clearance from the tip of the ETT to expand. If there is < 4 cm between the tip of the ETT and the carina, both limbs of the “Y” often end up in the right mainstem
- Although a larger ETT allows for more room for the EZBB and the scope, too large of an ETT will decrease the distance between the ETT tip and the carina
- In some patients, the BB balloon may be distal to the opening of the RUL bronchus. This might be rectified by placing > 10 ml of air into the BB balloon. A DLT may be preferred with RUL surgery
- The BB may dislodge when turning the patient



EZBB Placement Pearls

- Place the balloon of the ETT just past the vocal cords
- Do not use too large of an ETT, but it must be at least a 7.0
- Extend the neck before EZBB placement – this will create more vertical space in the trachea
- Keep the ETT in the center of the pharynx to avoid having the ETT curvature favor one mainstem bronchus
- Before insertion, orient the BB so that the “Y” is in a horizontal plane in reference to the patient



EZBB Management

- Re-check placement after placing patient lateral
- Allow time for the lung to collapse before inflating the BB – fill the lungs with 100% F_iO_2, then disconnect the circuit for at least 20 seconds before inflating the balloon
- If possible, keep peak airway pressures below 25 cm

LEFT SIDED DOUBLE LUMEN ETT

DLT issues
- May not be possible to place in patients who have history of difficult intubation
- Airway trauma more likely than with EZBB

DLT Placement Pearls
- Size - Females 37, but use 35 if < 5'3''
- Size - Males 39, but use 41 if > 5'9''
- The distal bronchial tube is held with the tip directed upward. As it passes through the glottis, the stylet is removed, and the tube is advanced and rotated 90 degrees towards the left until resistance is felt
- Extend the neck after intubation, before confirming the position
- Typical placement depth 28-30 cm

DLT Management
- Re-check placement after placing the patient lateral
- If possible, keep peak airway pressures below 25 cm
- Place operative lung under suction

Two-lung ventilation - if cannot ventilate or high PIP, either:
- In too far – tracheal lumen in bronchus
- Out too far – bronchial lumen in trachea, or bronchial cuff herniated over carina

One-lung Ventilation Problems – Left Surgery:
- In too far - LUL inflating – bronchial cuff past LUL bronchus
- Out too far - left lung inflating and high PIP – bronchial lumen or bronchial cuff in trachea

One-lung Ventilation Problems – Right Surgery:
- In too far – hypoxia - bronchial cuff past LUL bronchus
- Out too far - right lung inflating and high PIP – bronchial lumen or bronchial cuff in trachea