Endotracheal Suctioning of Mechanically Ventilated Patients With Artificial Airways 2010

An electronic literature search for articles published between January 1990 and October 2009 was conducted by using MEDLINE, CINAHL, and Cochrane Library databases. The update of this clinical practice guideline is the result of reviewing a total of 114 clinical trials, 62 reviews and 6 meta-analyses on endotracheal suctioning. The following recommendations are made following the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) criteria: (1) It is recommended that endotracheal suctioning should be performed only when secretions are present, and not routinely; (2) It is suggested that pre-oxygenation be considered if the patient has a clinically important reduction in oxygen saturation with suctioning; (3) Performing suctioning without disconnecting the patient from the ventilator is suggested; (4) Use of shallow suction is suggested instead of deep suction, based on evidence from infant and pediatric studies; (5) It is suggested that routine use of normal saline instillation prior to endotracheal suction should not be performed; (6) The use of closed suction is suggested for adults with high FIO2, or PEEP, or at risk for lung derecruitment, and for neonates; (7) Endotracheal suctioning without disconnection (closed system) is suggested in neonates; (8) Avoidance of disconnection and use of lung recruitment maneuvers are suggested if suctioning-induced lung derecruitment occurs in patients with acute lung injury; (9) It is suggested that a suction catheter is used that occludes less than 50% the lumen of the endotracheal tube in children and adults, and less than 70% in infants; (10) It is suggested that the duration of the suctioning event be limited to less than 15 seconds. Key words: closed suction; endotracheal suction; saline instillation; intratracheal suction; open suction; saline lavage; suction catheter; tracheal suction; clinical practice guideline.

ETS 1.0 DESCRIPTION

Endotracheal suctioning (ETS) is one of the most common procedures performed in patients with artificial airways. It is a component of bronchial hygiene therapy and mechanical ventilation that involves the mechanical aspiration of pulmonary secretions from a patient’s artificial airway to prevent its obstruction.1 The procedure includes patient preparation, the suctioning event, and follow-up care.

There are 2 methods of endotracheal suctioning based on the selection of catheter: open and closed. The open suctioning technique requires disconnecting the patient from the ventilator, while the closed suctioning technique involves attachment of a sterile, closed, in-line suction catheter to the ventilator circuit, which allows passage of a suction catheter through the artificial airway without disconnecting the patient from the ventilator. There are also 2 methods of suctioning based on the catheter suction depth selected during the procedure: deep and shallow. Deep suctioning is defined as the insertion of a suction catheter until resistance is met, followed by withdrawal of the catheter by 1 cm before application of negative pressure, and shallow suctioning as the insertion of a suction catheter to a predetermined depth, usually the length of the artificial airway plus the adapter.2

ETS 2.0 PATIENT PREPARATION

It is recommended to use smaller catheters whenever possible, since suction pressure seems to have less influence on lung volume loss than catheter size.3 For a given diameter of the endotracheal tube (ETT), the level of negative pressure transmitted to the airway is determined by the combination of the catheter size and the suction pressure. The larger the diameter of the catheter size, the less attenuation of the suction pressure through the airways.4

2.1 Diameter of the suction catheter should not exceed one half the inner diameter of the artificial airway in adults, providing an internal-to-external diameter ra-
In preparation for the suctioning event, delivery of 100% oxygen in pediatric and adult patients and 10% increase of baseline in neonates for 30–60 seconds prior to the suctioning event is suggested, especially in patients who are hypoxemic before suctioning. This may be accomplished either:

- by adjusting the FIO₂ setting on the mechanical ventilator, or
- by use of a temporary oxygen-enrichment program available on many microprocessor ventilators.

Manual ventilation of the patient is not recommended, as it has been shown to be ineffective for providing delivered FIO₂ of 1.0. Practitioners should ensure that PEEP is maintained if no other alternative is available to hyper-oxygenate.

The negative pressure of the unit must be checked by occluding the end of the suction tubing before attaching it to the suction catheter, and prior to each suctioning event. Suction pressure should be set as low as possible and yet effectively clear secretions. Experimental data to support an appropriate maximum suction level are lacking. Negative pressure of 80–100 mm Hg in neonates and less than 150 mm Hg in adults have been recommended.

The closed suctioning technique facilitates continuous mechanical ventilation and oxygenation during the suctioning event. It may prevent lung derecruitment associated with the use of open-suction system in patients at higher risk of desaturation (eg, premature newborns). It should be considered in patients requiring high FIO₂ and PEEP (eg, acute lung injury). It neither increases nor decreases the risk of ventilator-associated pneumonia. Daily changes of in-line suction catheters do not decrease the risk of ventilator-associated pneumonia and is not cost-effective.

A patient should be placed on a pulse oximeter to assess oxygenation during and following the procedure.

ETS 3.0 PROCEDURE

The suctioning event consists of the placement of a suction catheter through the artificial airway into the trachea and the application of negative pressure as the catheter is being withdrawn. Each pass of the suction catheter into the artificial airway is considered a suctioning event. Shallow suctioning is recommended to prevent trauma to the tracheal mucosa.

ETS 4.0 FOLLOW-UP CARE

Following the suctioning event:

- Hyper-oxygenation for at least 1 min by following the technique(s) used to pre-oxygenate the patient may be used, especially in patients who are hypoxemic before and/or during suctioning.
- Hyperventilation should not be routinely used. Lung-recruitment maneuvers may be attempted in patients with clear evidence of derecruitment.
- The patient should be monitored for adverse reactions.

ETS 5.0 SETTING

Endotracheal suctioning may be performed by properly trained persons in a wide variety of settings that include:

- Hospital
- Extended care facility
- Home
- Out-patient clinic
- Physician’s office
- Transport vehicle
ETS 6.0 INDICATIONS

6.1 The need to maintain the patency and integrity of the artificial airway
6.2 The need to remove accumulated pulmonary secretions as evidenced by one of:
   6.2.1 sawtooth pattern on the flow-volume loop on the monitor screen of the ventilator and/or the presence of coarse crackles over the trachea are strong indicators of retained pulmonary secretions56,57
   6.2.2 increased peak inspiratory pressure during volume-controlled mechanical ventilation or decreased tidal volume during pressure-controlled ventilation58
   6.2.3 deterioration of oxygen saturation and/or arterial blood gas values58
   6.2.4 visible secretions in the airway58
   6.2.5 patient’s inability to generate an effective spontaneous cough
   6.2.6 acute respiratory distress58
   6.2.7 suspected aspiration of gastric or upper-airway secretions
6.3 The need to obtain a sputum specimen to rule out or identify pneumonia or other pulmonary infection or for sputum cytology

ETS 7.0 CONTRAINDICATIONS

Endotracheal suctioning is a necessary procedure for patients with artificial airways. Most contraindications are relative to the patient’s risk of developing adverse reactions or worsening clinical condition as result of the procedure. When indicated, there is no absolute contraindication to endotracheal suctioning, because the decision to withhold suctioning in order to avoid a possible adverse reaction may, in fact, be lethal.

ETS 8.0 HAZARDS/COMPLICATIONS

8.1 Decrease in dynamic lung compliance59 and functional residual capacity60
8.2 Atelectasis52,57
8.3 Hypoxia/hypoxemia61,62
8.4 Tissue trauma to the tracheal and/or bronchial mucosa63
8.5 Bronchoconstriction/bronchospasm1,60
8.6 Increased microbial colonization of lower airway5,64
8.7 Changes in cerebral blood flow65,66 and increased intracranial pressure67-69
8.8 Hypertension70
8.9 Hypotension17
8.10 Cardiac dysrhythmias17

ETS 9.0 LIMITATIONS OF METHOD

Endotracheal suctioning is not a benign procedure, and operators should remain sensitive to possible hazards and complications and take all necessary precautions to ensure patient safety. Secretions in peripheral airways are not and should not be directly removed by endotracheal suctioning.

ETS 10.0 ASSESSMENT OF NEED

Qualified personnel should assess the need for endotracheal suctioning as a routine part of the patient/ventilator system assessment as detailed in section 6.0 Indications.

ETS 11.0 ASSESSMENT OF OUTCOME

11.1 Improvement in appearance of ventilator graphics and breath sounds57,58
11.2 Decreased peak inspiratory pressure with narrowing of peak inspiratory pressure-plateau pressure; decreased airway resistance or increased dynamic compliance; increased tidal volume delivery during pressure-limited ventilation
11.3 Improvement in arterial blood gas values or saturation, as reflected by pulse oximetry (\(S_{PO2}\))
11.4 Removal of pulmonary secretions

ETS 12.0 RESOURCES

12.1 Necessary Equipment
   12.1.1 Vacuum source
   12.1.2 Calibrated, adjustable regulator
   12.1.3 Collection bottle and connecting tubing
   12.1.4 Disposable gloves
      12.1.4.1 Sterile (open suction)
      12.1.4.2 Clean (closed suction)
   12.1.5 Sterile suction catheter
      12.1.5.1 For selective main-bronchus suctioning, a curved-tip catheter may be helpful.82
      The information related to the effectiveness of head turning for selective suctioning is inconclusive.
12.1.6 Sterile water and cup (open suction)
12.1.7 Goggles, mask, and other appropriate equipment for standard precautions
12.1.8 Oxygen source with a calibrated metering device
12.1.9 Pulse oximeter
12.1.10 Manual resuscitation bag equipped with an oxygen-enrichment device for emergency backup use
12.1.11 Stethoscope

12.2 Optional Equipment

12.2.1 Electrocardiograph
12.2.2 Sterile sputum trap for culture specimen

12.3 Personnel. Licensed or credentialed respiratory therapists or individuals with similar credentials (eg, MD, RN) who have the necessary training and demonstrated skills to correctly assess need for suctioning, perform the procedure, and adequately evaluate the patient after the procedure.

ETS 13.0 MONITORING

The following should be monitored prior to, during, and after the procedure:

13.1 Breath sounds
13.2 Oxygen saturation
  13.2.1 Skin color
  13.2.2 Pulse oximeter
13.3 Respiratory rate and pattern

13.4 Hemodynamic parameters
  13.4.1 Pulse rate
  13.4.2 Blood pressure, if indicated and available
  13.4.3 Electrocardiogram, if indicated and available

13.5 Sputum characteristics
  13.5.1 Color
  13.5.2 Volume
  13.5.3 Consistency
  13.5.4 Odor

13.6 Cough characteristics

13.7 Intracranial pressure, if indicated and available

13.8 Ventilator parameters
  13.8.1 Peak inspiratory pressure and plateau pressure
  13.8.2 Tidal volume
  13.8.3 Pressure, flow, and volume graphics, if available
  13.8.4 FIO2

ETS 14.0 FREQUENCY

Although the internal lumen of an ETT decreases substantially after a few days of intubation, due to formation of biofilm, suctioning should be performed only when clinically indicated in order to maintain the patency of the artificial airway used. Special consideration should be given to the potential complications associated with the procedure.

ETS 15.0 INFECTION CONTROL

15.1 Centers for Disease Control guidelines for standard precautions should be followed.
  15.1.1 If manual ventilation is used, care must be taken not to contaminate the airway.
  15.1.2 Sterile technique is encouraged during the entire suctioning event.
15.2 All equipment and supplies should be appropriately disposed of or disinfected.

ETS 16.0 RECOMMENDATIONS

The following recommendations are made following the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) criteria:

16.1 It is recommended that endotracheal suctioning should be performed only when secretions are present, and not routinely. (1C)
16.2 It is suggested that pre-oxygenation be considered if the patient has a clinically important reduction in oxygen saturation with suctioning. (2B)
16.3 Performing suctioning without disconnecting the patient from the ventilator is suggested. (2B)
16.4 Use of shallow suction is suggested instead of deep suction, based on evidence from infant and pediatric studies. (2B)
16.5 It is suggested that routine use of normal saline instillation prior to endotracheal suction should not be performed. (2C)
16.6 The use of closed suction is suggested for adults with high FIO2 or PEEP, or at risk for lung derecruitment (2B), and for neonates (2C).
16.7 Endotracheal suctioning without disconnection (closed system) is suggested in neonates. (2B)
16.8 Avoidance of disconnection and use of lung-recruitment maneuvers are suggested if suctioning-induced lung derecruitment occurs in patients with acute lung injury. (2B)
16.9 It is suggested that a suction catheter is used that occludes less than 50% of the lumen of the ETT in children and adults, and less than 70% in infants. (2C)
16.10 It is suggested that the duration of the suctioning event be limited to less than 15 seconds. (2C)

ETS CPG IDENTIFYING INFORMATION AND AVAILABILITY

17.1 Adaptation
Original Publication: Respir Care 1993;38(5):500-504.
REFERENCES


5. Tiffin NH, Keim MR, Frewen TC. The effects of variations in flow through an insufflating catheter and endotracheal-tube and suction-catheter size on test-lung pressures. Respir Care 1990;35(9):889-897.


